

Expat Plans Brochure

WellAway

wellaway.com

January 1, 2027

Why choose Wellaway?

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

You are always our priority. Our cultural diversity allows members to be serviced with the utmost consideration for their expatriate lifestyle. With worldwide coverage and access to the UnitedHealthcare Global network of over 1.2M+ providers in the U.S., we aim to provide stability and security for individuals, families and groups on the forefront of health insurance globalization.



- Full Medical Plans
- Emergency Medical Assistance
- Multi-Lingual Customer Service
- Telemedicine Services
- Medical Evacuation and Repatriation
- Competitive Pricing

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



Telehealth

Access to your doctor 24/7

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

- Receive quality care via phone, video or mobile app.
- Prompt treatment. Talk to your doctor in minutes.



Get The Care You Need

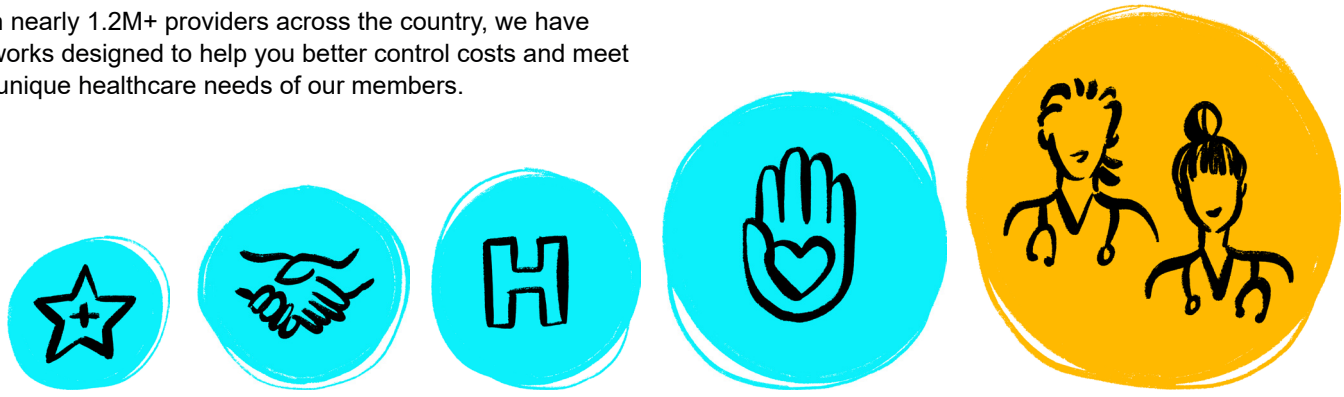
Using Telehealth to speak with your doctors can treat many medical conditions, including but not limited to:

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

Our Health Partner: UnitedHealthcare Global

Networks that deliver greater accountability and value.

With nearly 1.2M+ providers across the country, we have networks designed to help you better control costs and meet the unique healthcare needs of our members.



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

Expat Plans

An international health plan with Worldwide coverage for expatriates. Expat Gold offers a maximum annual coverage of $1,000,000 and Expat Diamond and Expat Plus plans offer a maximum annual coverage of $3,000,000.

Geographical Zones and Coverage

Expat Plans are categorized within one of the 2 zones below based on the destination at the time of purchase. European citizens residing in one of the countries of the European Union are ineligible for the Expat plans.

Zone 1	Zone 2
Zone 1 is worldwide excluding your Country of Origin, the European Union if you permanently reside there and the Restricted Areas (as defined in the Definitions Section of this Policy).	Zone 2 is worldwide excluding the USA, Bahamas, Bermuda, Brazil, Canada, China, Hong Kong, Japan, Panama, Singapore, Switzerland, United Kingdom, your Country of Origin, the European Union if you permanently reside there and the Restricted Areas.

The Expat plans offer worldwide travel coverage as follows:

- **Zone 1:** up to 30 days of coverage in Country of Origin or the European Union
- **Zone 2:** up to 30 days of coverage in Country of Origin or the European Union

Coverage Highlights

Maximum Annual Coverage :
$1,000,000 or $3,000,000 USD

The Expat Plans are affordable and each plan includes Preventive care, Inpatient care and International Medical Evacuation & Repatriation.

- Plan Coverage limits: Gold $1,000,000 USD
  Diamond & Expat Plus $3,000,000 USD
- Gold and Diamond plans offer flexible options with 3 different deductibles to choose from.
- Expat Plus offers the most comprehensive level of coverage, featuring a $0 Deductible and 0% coinsurance.
- See a variety of doctors with no need of a referral to consult a specialist.
- Unmarried dependent children are covered up to age 26 if in full-time education.
- Provider Access within the U.S.: Access to Premium Care Physicians and at In-Network Facilities with UnitedHealthcare Global.
- Provider Access outside of the U.S.: An open-access network allows you the flexibility to see a variety of doctors.
- 24/7 multi-lingual ConciergeCare services dedicated to support you and your family.

Gold, Diamond and Plus Cover:

Gold

Maximum Annual Coverage: $1,000,000
Eligibility Ages: 18-60

- Inpatient Care
- Outpatient Care
- Telemedicine*
- Preventive Benefits
- International Medical Evacuation & Repatriation
- Dental and Vision Benefits
- Pre-existing conditions

Diamond

Maximum Annual Coverage: $3,000,000
Eligibility Ages: 18-60

- Inpatient Care
- Outpatient Care
- Telemedicine*
- Preventive Benefits
- International Medical Evacuation & Repatriation
- Dental and Vision Benefits
- Pre-existing conditions

Plus

Maximum Annual Coverage: $3,000,000
Eligibility Ages: 18-60

- $0 Deductible
- 0% Coinsurance
- Inpatient Care
- Outpatient Care
- Telemedicine*
- Preventive Benefits
- International Medical Evacuation & Repatriation
- Dental and Vision Benefits
- Pre-existing conditions

Covered Optional Not covered Upgraded Costshare

Expat Plans Summary of Benefits

All benefits are subject to the limitations and exclusions contained in the Policy. Our ConciergeCare team will help you locate the most appropriate Provider and assist you in scheduling an appointment.

Important Points You Should Know

- Maximum amounts apply to certain services.
- Benefits are shown per person, per policy year.
- Certain Benefits are only available when you utilize a Premium Care/Select Provider.
- Pre-authorization is required for certain services. Please refer to the terms and conditions of the policy.
- The UnitedHealth Global program has a wide network of providers which have been evaluated based on cost and quality of health care. The program evaluates physicians in various specialties using evidence-based medicine and national standardized measures to help you locate quality and cost-efficient providers. It's easy to find a UnitedHealth Premium Care Physician when you visit https://www.wellaway.com/provider-search/ and click on UnitedHealthcare. Click **Find a Doctor** and look for the blue hearts.
- If there is no Premium Care/Select Provider or In-Network Provider located within a 50-mile radius of your local residence, the claim will be paid as In-Network subject to Allowable Charges or at the Rate of a similarly situated In-Network Provider, after applicable Cost Share amounts have been applied.
- This Policy is designed to cover the necessary treatment of new medical conditions that arises after the effective date of coverage. A Pre-existing condition is any health issue or Illness that existed prior to the effective date of coverage.
- The plans are not subject to, and do not provide insurance benefits required by the United States Patient Protection and Affordable Care Act ("PPACA"). PPACA requires certain U.S. citizens or U.S. residents to obtain PPACA compliant health insurance plans or "minimum essential coverage".

Deductible and Coinsurance Options

	Deductible	Coinsurance	Out-of-Pocket Maximum
Plan Selection	The deductible is the amount the member pays towards the cost of treatment before any reimbursement is made.	This amount is the percentage the member must pay toward the cost of the treatment.	This is maximum amount of cost share the member pays per period of cover, not inclusive of not covered amounts.
Expat Gold	$1,000 – Individual $2,000 – Family	20%	$5,000 – Individual $10,000 – Family
	$2,000 – Individual $4,000 – Family	20%	$6,000 – Individual $12,000 – Family
	$5,000 – Individual $10,000 – Family	20%	$7,000 – Individual $14,000 – Family
Expat Diamond	$1,000 – Individual $2,000 – Family	0%	$1,000 – Individual $2,000 – Family
	$2,000 – Individual $4,000 – Family	0%	$2,000 – Individual $4,000 – Family
	$5,000 – Individual $10,000 – Family	0%	$5,000 – Individual $10,000 – Family
Expat Plus	$0 – Individual $0 – Family	0%	N/A

Expat Gold Member Responsibility	1000			2000			5000		
Limit & Cost Sharing	**In-Network**	**Out-of-Network**	**Worldwide**	**In-Network**	**Out-of-Network**	**Worldwide**	**In-Network**	**Out-of-Network**	**Worldwide**
Deductible	$1,000 – Individual $2,000 – Family	$1,000 – Individual $2,000 – Family	$1,000 – Individual $2,000 – Family	$2,000 – Individual $4,000 – Family	$2,000 – Individual $4,000 – Family	$2,000 – Individual $4,000 – Family	$5,000 – Individual $10,000 – Family	$5,000 – Individual $10,000 – Family	$5,000 – Individual $10,000 – Family
In-Network Coinsurance (You Pay)	20%	N/A	No Coinsurance	20%	N/A	No Coinsurance	20%	N/A	No Coinsurance
Out-of-Network Fee Schedule	N/A	50%	N/A	N/A	50%	N/A	N/A	50%	N/A
Out-of-Pocket Maximum *(In-Network Deductible and In-Network Coinsurance amounts accrue towards the Out-of-Pocket Maximum)*	$5,000 – Individual $10,000 – Family	Unlimited Individual and Family	Unlimited Individual and Family	$6,000 – Individual $12,000 – Family	Unlimited Individual and Family	Unlimited Individual and Family	$7,000 – Individual $14,000 – Family	Unlimited Individual and Family	Unlimited Individual and Family
Expat Gold What Your Plan Pays									
Maximum Annual Coverage	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000

Benefits are subject to the limitations and exclusions contained in the Policy.
All Treatment must be Medically Necessary.
Services with an asterisk must be Pre-Authorized by Plan Administrator.

Preventive Services

These Services must be performed in an In-Network Premium Care Physician's/Select Provider's office or free-standing Facility only. If Services are not performed in an In-Network Premium Care Physician's/Select Provider's office or free-standing Facility, Services will not be covered.

	USA Benefits Zone 1		Worldwide Benefits Zone 1 & 2	USA Benefits Zone 1		Worldwide Benefits Zone 1 & 2	USA Benefits Zone 1		Worldwide Benefits Zone 1 & 2
	In-Network	Out-of-Network		In-Network	Out-of-Network		In-Network	Out-of-Network	
DEDUCTIBLE DOES NOT APPLY TO THIS BENEFIT									
Annual Physical Examination									
Adult Annual Physical Exam includes: • CBC, lipid profile, blood glucose, urinalysis, thyroid, blood pressure measure, heart rates, weight and BMI • Papanicolaou (PAP) screening • Mammogram (eligible age: 40 years and over) • PSA screening test (eligible age: 55 years and over)	No Coinsurance	Not covered	No Coinsurance	No Coinsurance	Not covered	No Coinsurance	No Coinsurance	Not covered	No Coinsurance
Immunizations: Flu shot and COVID-19 vaccine only									
Child Periodic Preventative visits									
Periodic preventive services are age specific for children and babies up to 16 years of age. After 3 years of age, children should have one preventive visit per year up to age 21. Pediatric visits should follow the intervals recommended by the age specific schedule of the Pediatric Guidelines.									

Services That Require Hospitalization

Certain Services require you to use an In-Network Premium Care/Select Provider and/or free-standing Facility (as indicated below). For all other Services, we highly recommend that you use an In-Network Premium Care/Select Provider and free-standing Facility. Non-Premium Care/Select Providers and hospital affiliated Facilities, while In-Network, may be subject to excess or differentials in addition to your Cost Share amounts. Seeking care from Providers who do not participate in our Network or are Non-Network Providers typically results in greater cost to you. A search feature is available to help you find local Network Providers by using the link provided on the reverse side of your ID card or calling the telephone number also located on the reverse side of your ID card. You should always verify a Provider's participation status before you receive Services. To verify a Provider's specialty or participation status, you may contact our ConciergeCare Team or access the most recent provider directory at the provider directory online.

Pre-Admission Testing (must be performed 3-5 days in advance in a Physician's office or at a participating lab under the order of the admitting Physician)	20%	50%	No Coinsurance	20%	50%	No Coinsurance	20%	50%	No Coinsurance
Inpatient Hospitalization* (room & board, Inpatient general nursing care and special diets)	The first day of hospitalization is covered at 100% of the Average Semi-Private Room Rate. Thereafter, the Insured Person pays 20% Coinsurance of the Average Semi-Private room rate, subject to the $2,000 maximum daily benefit.	The first day of hospitalization is covered at 100% of the Average Semi-Private Room Rate. Thereafter, the Insured Person pays 50% Coinsurance of the Average Semi-Private room rate, subject to the $2,000 maximum daily benefit.	No Coinsurance	The first day of hospitalization is covered at 100% of the Average Semi-Private Room Rate. Thereafter, the Insured Person pays 20% Coinsurance of the Average Semi-Private room rate, subject to the $2,000 maximum daily benefit.	The first day of hospitalization is covered at 100% of the Average Semi-Private Room Rate. Thereafter, the Insured Person pays 50% Coinsurance of the Average Semi-Private room rate, subject to the $2,000 maximum daily benefit.	No Coinsurance	The first day of hospitalization is covered at 100% of the Average Semi-Private Room Rate. Thereafter, the Insured Person pays 20% Coinsurance of the Average Semi-Private room rate, subject to the $2,000 maximum daily benefit.	The first day of hospitalization is covered at 100% of the Average Semi-Private Room Rate. Thereafter, the Insured Person pays 50% Coinsurance of the Average Semi-Private room rate, subject to the $2,000 maximum daily benefit.	No Coinsurance
Intensive Care Unit/Telemetry/Surgical Intensive Care/Medical Intensive Care/ Trauma/Pediatric Intensive Care*	20% (Maximum 180 days per Policy Year)	50% (Maximum 180 days per Policy Year)	No Coinsurance (Maximum 180 days per Policy Year)	20% (Maximum 180 days per Policy Year)	50% (Maximum 180 days per Policy Year)	No Coinsurance (Maximum 180 days per Policy Year)	20% (Maximum 180 days per Policy Year)	50% (Maximum 180 days per Policy Year)	No Coinsurance (Maximum 180 days per Policy Year)

**Pre-Authorization Required*

Expat Gold	1000			2000			5000		
Services That Require Hospitalization									
Certain Services require you to use an In-Network Premium Care/Select Provider and/or free-standing Facility (as indicated below). For all other Services, we highly recommend that you use an In-Network Premium Care/Select Provider and free-standing Facility. Non-Premium Care/Select Providers and hospital affiliated Facilities, while In-Network, may be subject to excess or differentials in addition to your Cost Share amounts. Seeking care from Providers who do not participate in our Network or are Non-Network Providers typically results in greater cost to you. A search feature is available to help you find local Network Providers by using the link provided on the reverse side of your ID card or calling the telephone number also located on the reverse side of your ID card. You should always verify a Provider's participation status before you receive Services. To verify a Provider's specialty or participation status, you may contact our ConciergeCare Team or access the most recent provider directory at the provider directory online.									
	USA Benefits Zone 1		**Worldwide Benefits Zone 1 & 2**	**USA Benefits Zone 1**		**Worldwide Benefits Zone 1 & 2**	**USA Benefits Zone 1**		**Worldwide Benefits Zone 1 & 2**
	In-Network	Out-of-Network		In-Network	Out-of-Network		In-Network	Out-of-Network	
Inpatient Mental Health* (Treatment must be provided in an accredited Psychiatric unit of a Hospital and must be under the direct control of a Psychiatric Physician)	20% Maximum 10 days per Policy Year	50% Maximum 5 days per Policy Year	No Coinsurance Maximum 10 days per Policy Year	20% Maximum 10 days per Policy Year	50% Maximum 5 days per Policy Year	No Coinsurance Maximum 10 days per Policy Year	20% Maximum 10 days per Policy Year	50% Maximum 5 days per Policy Year	No Coinsurance Maximum 10 days per Policy Year
Emergency Medical Services in an Emergency Room (Treatment for a sudden onset of a medical condition with Acute symptoms of sufficient severity that in the absence of immediate medical attention (or as soon as care can be made available, but not any later than 24 hours after the onset) and in the absence of which, if left untreated, could reasonably result in a significant deterioration in health) If you use an Emergency room in the Hospital for a non-emergency Service, the Services will not be covered.	20%	50%	20%	20%	50%	20%	20%	50%	20%
Inpatient Physician and Specialist Services	20% (Maximum 1 specialty per day)	50% (Maximum 1 specialty per day)	No Coinsurance (Maximum 1 specialty per day)	20% (Maximum 1 specialty per day)	50% (Maximum 1 specialty per day)	No Coinsurance (Maximum 1 specialty per day)	20% (Maximum 1 specialty per day)	50% (Maximum 1 specialty per day)	No Coinsurance (Maximum 1 specialty per day)
Inpatient Advanced Diagnostic Services (e.g., MRI, CT scans, nuclear imaging)	20% Maximum Benefit $1,000 per Service	50% Maximum Benefit $700 per Service	No Coinsurance Maximum Benefit $1,000 per Service	20% Maximum Benefit $1,000 per Service	50% Maximum Benefit $700 per Service	No Coinsurance Maximum Benefit $1,000 per Service	20% Maximum Benefit $1,000 per Service	50% Maximum Benefit $700 per Service	No Coinsurance Maximum Benefit $1,000 per Service
Inpatient Routine X-rays and Lab Tests (tests commonly performed while Inpatient)	20%	50%	No Coinsurance	20%	50%	No Coinsurance	20%	50%	No Coinsurance
Inpatient Renal Failure Dialysis* (for Acute Renal Failure which is not the result or complication of a Chronic Condition)	20% Maximum Benefit $25,000 per Policy Year	50% Maximum Benefit $25,000 per Policy Year	No Coinsurance Maximum Benefit $25,000 per Policy Year	20% Maximum Benefit $25,000 per Policy Year	50% Maximum Benefit $25,000 per Policy Year	No Coinsurance Maximum Benefit $25,000 per Policy Year	20% Maximum Benefit $25,000 per Policy Year	50% Maximum Benefit $25,000 per Policy Year	No Coinsurance Maximum Benefit $25,000 per Policy Year
Inpatient Oncology Treatment* (includes diagnostic tests, oncologist fees, radiation therapy and chemotherapy alone or in combination from the point of diagnosis and pharmaceutical treatments which have approved efficacy and market distribution) Benefits are only available when you utilize a Premium Care/Select Provider.	20% Maximum Benefit $150,000	Not covered	No Coinsurance Maximum Benefit $150,000	20% Maximum Benefit $150,000	Not covered	No Coinsurance Maximum Benefit $150,000	20% Maximum Benefit $150,000	Not covered	No Coinsurance Maximum Benefit $150,000
Inpatient Reconstructive Surgery* (resulting from an Illness or Injury e.g., breast reconstruction or other bodily reconstruction due to trauma, infection, tumors or disease that will improve function and ability) Benefits are only available when you utilize a Premium Care/Select Provider.	20% Maximum Benefit $50,000	Not covered	No Coinsurance Maximum Benefit $50,000	20% Maximum Benefit $50,000	Not covered	No Coinsurance Maximum Benefit $50,000	20% Maximum Benefit $50,000	Not covered	No Coinsurance Maximum Benefit $50,000
Inpatient Rehabilitation* (physical, occupational and speech therapy for the purpose of restoring the previous state of health after an Illness or Injury) Benefits are only available when you utilize a Premium Care/Select Provider.	20% Maximum 30 days per Policy Year	Not covered	No Coinsurance Maximum 30 days per Policy Year	20% Maximum 30 days per Policy Year	Not covered	No Coinsurance Maximum 30 days per Policy Year	20% Maximum 30 days per Policy Year	Not covered	No Coinsurance Maximum 30 days per Policy Year
Inpatient Surgical Procedures and Surgeon Fees * • Surgeon's fees for Medically Necessary Treatments related to an Injury or Illness which are charged by the main surgeon that performed the Surgical procedure. • Some complex medical procedures may require an assistant surgeon or co-surgeon performing services. This applies only to procedures for which an assistant surgeon or co-surgeon is indicated by Medical Necessity and evidence-based medicine. Claims in the United States will be paid based on AMA guidelines for assistant surgeons and surgery reimbursements. International Claims will be paid based on UCR. • Services of an Anesthesiologist, other than the operating Surgeon or Assistant Surgeon, who administers anesthesia for a covered Surgical Procedure are also covered.	20%	50%	No Coinsurance	20%	50%	No Coinsurance	20%	50%	No Coinsurance

**Pre-Authorization Required*

Expat Gold	1000			2000			5000		
Services That Require Hospitalization									
Certain Services require you to use an In-Network Premium Care/Select Provider and/or free-standing Facility (as indicated below). For all other Services, we highly recommend that you use an In-Network Premium Care/Select Provider and free-standing Facility. Non-Premium Care/Select Providers and hospital affiliated Facilities, while In-Network, may be subject to excess or differentials in addition to your Cost Share amounts. Seeking care from Providers who do not participate in our Network or are Non-Network Providers typically results in greater cost to you. A search feature is available to help you find local Network Providers by using the link provided on the reverse side of your ID card or calling the telephone number also located on the reverse side of your ID card. You should always verify a Provider's participation status before you receive Services. To verify a Provider's specialty or participation status, you may contact our ConciergeCare Team or access the most recent provider directory at the provider directory online.									
	USA Benefits Zone 1		**Worldwide Benefits Zone 1 & 2**	**USA Benefits Zone 1**		**Worldwide Benefits Zone 1 & 2**	**USA Benefits Zone 1**		**Worldwide Benefits Zone 1 & 2**
	In-Network	Out-of-Network		In-Network	Out-of-Network		In-Network	Out-of-Network	
Inpatient Surgical Appliances and Prosthesis (covered for prosthetic, surgical, orthopedic and cardiac Procedures which are an integral part of the Surgical Procedure) Please refer to your Policy for a list of devices, appliances or prostheses that may be excluded.	20% Maximum Benefit $10,000	50% Maximum Benefit $10,000	No Coinsurance Maximum Benefit $10,000	20% Maximum Benefit $10,000	50% Maximum Benefit $10,000	No Coinsurance Maximum Benefit $10,000	20% Maximum Benefit $10,000	50% Maximum Benefit $10,000	No Coinsurance Maximum Benefit $10,000
Organ Transplant* • Includes heart, heart and lung, kidney, kidney and pancreas, liver, cornea, bone and skin grafts, small intestines and allogenic and autologous, bone marrow (refer to your Policy for coverage of approved Diagnosis), blood and stem cell transplants. Benefits are only available when you utilize a Premium Care/Select Provider.	20% Maximum Benefit $50,000 Lifetime	Not covered	No Coinsurance Maximum Benefit $50,000 Lifetime	20% Maximum Benefit $50,000 Lifetime	Not covered	No Coinsurance Maximum Benefit $50,000 Lifetime	20% Maximum Benefit $50,000 Lifetime	Not covered	No Coinsurance Maximum Benefit $50,000 Lifetime
Emergency Ground Ambulance (limited to one way trip when responding to a medical Emergency where other means of transportation will endanger the patient life or special medical equipment must be used en route to the closest medical Facility available to treat the emergency that results in an Inpatient Admission)	20%	20%	20%	20%	20%	20%	20%	20%	20%
Outpatient Care									
Certain Services require you to use an In-Network Premium Care/Select Provider and/or free-standing Facility (as indicated below). For all other Services, we highly recommend that you use an In-Network Premium Care/Select Provider and/or free-standing Facility. Non-Premium Care/Select Providers and hospital affiliated Facilities, while In-Network, may be subject to excess or differentials in addition to your Cost Share amounts. Seeking care from Providers who do not participate in our Network or are Non-Network Providers typically results in greater cost to you. You should always verify a Provider's participation status before you receive Services. To verify a Provider's specialty or participation status, you may contact our ConciergeCare Team or access the most recent provider directory at the provider directory online. 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.									
Urgent Care Clinic / Facility	20%	50%	No Coinsurance	20%	50%	No Coinsurance	20%	50%	No Coinsurance
Outpatient Ambulatory Surgical Facility & Surgical Care* • Surgeon's fees for Medically Necessary Treatments related to an Injury or Illness which are charged by the main surgeon that performed the Surgical procedure. • Some complex medical procedures may require an assistant surgeon or co-surgeon performing services. This applies only to procedures for which an assistant surgeon or co-surgeon is indicated by Medical Necessity and evidence-based medicine. Claims in the United States will be paid based on AMA guidelines for assistant surgeons and surgery reimbursements. International Claims will be paid based on UCR. • Services of an Anesthesiologist, other than the operating Surgeon or Assistant Surgeon, who administers anesthesia for a covered Surgical Procedure are also covered.	20%	50%	No Coinsurance	20%	50%	No Coinsurance	20%	50%	No Coinsurance
Routine X-rays and Laboratory Tests Benefits are only available when performed in a Premium Care Physician/Select Provider's office or in a free-standing non-hospital Facility.	20%	Not covered	No Coinsurance	20%	Not covered	No Coinsurance	20%	Not covered	No Coinsurance
Advanced Diagnostic and Interventional Radiology Services* Benefits are only available when performed in a Premium Care Physician/Select Provider's office or in a free-standing non-hospital Facility.	20% Maximum Benefit $3,000 per Policy Year	Not covered	No Coinsurance Maximum Benefit $3,000 per Policy Year	20% Maximum Benefit $3,000 per Policy Year	Not covered	No Coinsurance Maximum Benefit $3,000 per Policy Year	20% Maximum Benefit $3,000 per Policy Year	Not covered	No Coinsurance Maximum Benefit $3,000 per Policy Year

**Pre-Authorization Required*

Expat Gold	1000			2000			5000		
Outpatient Care									
Certain Services require you to use an In-Network Premium Care/Select Provider and/or free-standing Facility (as indicated below). For all other Services, we highly recommend that you use an In-Network Premium Care/Select Provider and/or free-standing Facility. Non-Premium Care/Select Providers and hospital affiliated Facilities, while In-Network, may be subject to excess or differentials in addition to your Cost Share amounts. Seeking care from Providers who do not participate in our Network or are Non-Network Providers typically results in greater cost to you. You should always verify a Provider's participation status before you receive Services. To verify a Provider's specialty or participation status, you may contact our ConciergeCare Team or access the most recent provider directory at the provider directory online. 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.									
	USA Benefits Zone 1		**Worldwide Benefits Zone 1 & 2**	**USA Benefits Zone 1**		**Worldwide Benefits Zone 1 & 2**	**USA Benefits Zone 1**		**Worldwide Benefits Zone 1 & 2**
	In-Network	Out-of-Network		In-Network	Out-of-Network		In-Network	Out-of-Network	
Outpatient Therapeutic Services Combined (physical, occupational and speech therapy for the purpose of restoring the previous state of health after an Illness or Injury)	20% Maximum allowance $100 per session, Maximum 20 sessions per Policy Year	Not covered	No Coinsurance Maximum allowance $100 per session, Maximum 20 sessions per Policy Year	20% Maximum allowance $100 per session, Maximum 20 sessions per Policy Year	Not covered	No Coinsurance Maximum allowance $100 per session, Maximum 20 sessions per Policy Year	20% Maximum allowance $100 per session, Maximum 20 sessions per Policy Year	Not covered	No Coinsurance Maximum allowance $100 per session, Maximum 20 sessions per Policy Year
Outpatient Renal Failure Dialysis* (for Acute Renal Failure which is not the result or complication of a Chronic Condition)	20% Maximum Benefit $25,000 per Policy Year	Not covered	No Coinsurance Maximum Benefit $25,000 per Policy Year	20% Maximum Benefit $25,000 per Policy Year	Not covered	No Coinsurance Maximum Benefit $25,000 per Policy Year	20% Maximum Benefit $25,000 per Policy Year	Not covered	No Coinsurance Maximum Benefit $25,000 per Policy Year
Outpatient Oncology Treatment* (includes diagnostic tests, oncologist fees, radiation therapy and chemotherapy alone or in combination from the point of diagnosis and pharmaceutical treatments which have approved efficacy and market distribution) Benefits are only available when you utilize a Premium Care/Select Provider.	20% Maximum Benefit $150,000 per Policy Year	Not covered	No Coinsurance Maximum Benefit $150,000 per Policy Year	20% Maximum Benefit $150,000 per Policy Year	Not covered	No Coinsurance Maximum Benefit $150,000 per Policy Year	20% Maximum Benefit $150,000 per Policy Year	Not covered	No Coinsurance Maximum Benefit $150,000 per Policy Year
Outpatient 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). Benefits are only available when you utilize a Premium Care/Select Provider.	20% Maximum Benefit $50,000 per Policy Year	Not covered	No Coinsurance Maximum Benefit $50,000 per Policy Year	20% Maximum Benefit $50,000 per Policy Year	Not covered	No Coinsurance Maximum Benefit $50,000 per Policy Year	20% Maximum Benefit $50,000 per Policy Year	Not covered	No Coinsurance Maximum Benefit $50,000 per Policy Year
Outpatient Emergency Dental Treatment (due to Accident or Injury and resulting in damage to Sound Natural Tooth and treated within 24 hours of the Emergency event)	20% Maximum Benefit $250 per tooth up to $1,000 per Policy Year	Not covered	No Coinsurance Maximum Benefit $250 per tooth up to $1,000 per Policy Year	20% Maximum Benefit $250 per tooth up to $1,000 per Policy Year	Not covered	No Coinsurance Maximum Benefit $250 per tooth up to $1,000 per Policy Year	20% Maximum Benefit $250 per tooth up to $1,000 per Policy Year	Not covered	No Coinsurance Maximum Benefit $250 per tooth up to $1,000 per Policy Year
Home Health Care* (care must begin immediately following your Hospital stay of no less than 3 days, ordered by a Physician and provided under the supervision of a registered nurse)	20% Maximum 30 days per Policy Year following discharge of a Hospital admission of at least 3 days	Not covered	No Coinsurance Maximum 30 days per Policy Year following discharge of a Hospital admission of at least 3 days	20% Maximum 30 days per Policy Year following discharge of a Hospital admission of at least 3 days	Not covered	No Coinsurance Maximum 30 days per Policy Year following discharge of a Hospital admission of at least 3 days	20% Maximum 30 days per Policy Year following discharge of a Hospital admission of at least 3 days	Not covered	No Coinsurance Maximum 30 days per Policy Year following discharge of a Hospital admission of at least 3 days
Hospice or Palliative Care* (accommodation, nursing care and support for the Treatment of end-of-life stages)	20% Maximum Benefit $15,000 or 60 days per Policy Year, whichever occurs first	Not covered	No Coinsurance Maximum Benefit $15,000 or 60 days per Policy Year, whichever occurs first	20% Maximum Benefit $15,000 or 60 days per Policy Year, whichever occurs first	Not covered	No Coinsurance Maximum Benefit $15,000 or 60 days per Policy Year, whichever occurs first	20% Maximum Benefit $15,000 or 60 days per Policy Year, whichever occurs first	Not covered	No Coinsurance Maximum Benefit $15,000 or 60 days per Policy Year, whichever occurs first
Durable Medical Equipment (helps to complete your daily activities e.g., walker, wheelchair, oxygen device or other equipment that can withstand repeated use which must be prescribed by a Physician)	20% Maximum Benefit $1,500 per Policy Year	50% Maximum Benefit $750 per Policy Year	No Coinsurance Maximum Benefit $1,500 per Policy Year	20% Maximum Benefit $1,500 per Policy Year	50% Maximum Benefit $750 per Policy Year	No Coinsurance Maximum Benefit $1,500 per Policy Year	20% Maximum Benefit $1,500 per Policy Year	50% Maximum Benefit $750 per Policy Year	No Coinsurance Maximum Benefit $1,500 per Policy Year
Physician Services									
Certain Services require you to use an In-Network Premium Care/Select Provider and/or free-standing Facility (as indicated below). For all other Services, we highly recommend that you use an In-Network Premium Care/Select Provider and/or free-standing Facility. Non-Premium Care/Select Providers and hospital affiliated Facilities, while In-Network, may be subject to excess or differentials in addition to your Cost Share amounts. Seeking care from Providers who do not participate in our Network or are Non-Network Providers typically results in greater cost to you. You should always verify a Provider's participation status before you receive Services. To verify a Provider's specialty or participation status, you may contact our ConciergeCare Team or access the most recent provider directory at the provider directory online.									
Telemedicine Consultations and Visits (for Illnesses including cold & flu Symptoms, allergies, pink eye, respiratory infection, sinus problems and skin problems)	No Co-payment Maximum 8 consults per Policy Year		only available in the USA	No Co-payment Maximum 8 consults per Policy Year		only available in the USA	No Co-payment Maximum 8 consults per Policy Year		only available in the USA
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)	20% Maximum allowance $150 per visit	50% Maximum allowance $75 per visit	No Coinsurance Maximum allowance $150 per visit	20% Maximum allowance $150 per visit	50% Maximum allowance $75 per visit	No Coinsurance Maximum allowance $150 per visit	20% Maximum allowance $150 per visit	50% Maximum allowance $75 per visit	No Coinsurance Maximum allowance $150 per visit

**Pre-Authorization Required*

Expat Gold	1000			2000			5000		
Physician Services									
Certain Services require you to use an In-Network Premium Care/Select Provider and/or free-standing Facility (as indicated below). For all other Services, we highly recommend that you use an In-Network Premium Care/Select Provider and/or free-standing Facility. Non-Premium Care/Select Providers and hospital affiliated Facilities, while In-Network, may be subject to excess or differentials in addition to your Cost Share amounts. Seeking care from Providers who do not participate in our Network or are Non-Network Providers typically results in greater cost to you. You should always verify a Provider's participation status before you receive Services. To verify a Provider's specialty or participation status, you may contact our ConciergeCare Team or access the most recent provider directory at the provider directory online.									
	USA Benefits Zone 1		**Worldwide Benefits Zone 1 & 2**	**USA Benefits Zone 1**		**Worldwide Benefits Zone 1 & 2**	**USA Benefits Zone 1**		**Worldwide Benefits Zone 1 & 2**
	In-Network	Out-of-Network		In-Network	Out-of-Network		In-Network	Out-of-Network	
Primary Care Visit (includes Physicians, general or Family practitioner and gynecologist, when designated as the Primary Care Physician who provides the first contact for an individual with an undiagnosed health issue) Benefits are only available when you utilize a Premium Care/Select Provider.	20% Maximum allowance $150 per visit	Not covered	No Coinsurance Maximum allowance $150 per visit	20% Maximum allowance $150 per visit	Not covered	No Coinsurance Maximum allowance $150 per visit	20% Maximum allowance $150 per visit	Not covered	No Coinsurance Maximum allowance $150 per visit
Specialist Visit • When medically indicated • When your medical condition or Diagnosis requires that you are treated by a Physician with specific training for your condition or Diagnosis Benefits are only available when you utilize a Premium Care/Select Provider.	20% Maximum allowance $300 per visit	Not covered	No Coinsurance Maximum allowance $300 per visit	20% Maximum allowance $300 per visit	Not covered	No Coinsurance Maximum allowance $300 per visit	20% Maximum allowance $300 per visit	Not covered	No Coinsurance Maximum allowance $300 per visit
Outpatient Mental Health Visit (Treatment must be provided via e-visit or in a Physician's office under the direct control of a Psychiatric Physician)	20% Maximum 10 visits per Policy Year	50% Maximum 5 visits per Policy Year	No Coinsurance Maximum 10 visits per Policy Year	20% Maximum 10 visits per Policy Year	50% Maximum 5 visits per Policy Year	No Coinsurance Maximum 10 visits per Policy Year	20% Maximum 10 visits per Policy Year	50% Maximum 5 visits per Policy Year	No Coinsurance Maximum 10 visits per Policy Year
Alternative Medicine (acupuncture, chiropractic, homeopathy only)	20% Maximum allowance $100 per session Combined Maximum 5 visits per Policy Year	Not covered	No Coinsurance Maximum allowance $100 per session Combined Maximum 5 visits per Policy Year	20% Maximum allowance $100 per session Combined Maximum 5 visits per Policy Year	Not covered	No Coinsurance Maximum allowance $100 per session Combined Maximum 5 visits per Policy Year	20% Maximum allowance $100 per session Combined Maximum 5 visits per Policy Year	Not covered	No Coinsurance Maximum allowance $100 per session Combined Maximum 5 visits per Policy Year
Podiatry (Treatment for bursitis, heel spur, plantar fasciitis, ingrown toenail, infections, warts (including plantar warts), and fungal infections) Routine foot care and any Surgery of the foot are not covered under this benefit.	20% Maximum allowance $100 per session Maximum 5 visits per Policy Year	Not covered	No Coinsurance Maximum allowance $100 per session Maximum 5 visits per Policy Year	20% Maximum allowance $100 per session Maximum 5 visits per Policy Year	Not covered	No Coinsurance Maximum allowance $100 per session Maximum 5 visits per Policy Year	20% Maximum allowance $100 per session Maximum 5 visits per Policy Year	Not covered	No Coinsurance Maximum allowance $100 per session Maximum 5 visits per Policy Year
Allergy Testing & Treatment* (includes injections for allergies, may include desensitization therapy and the cost of hypo-sensitization serum) Benefits are only available when you utilize a Premium Care/Select Provider.	20%	Not covered	No Coinsurance	20%	Not covered	No Coinsurance	20%	Not covered	No Coinsurance
Outpatient Prescription Drugs and Supplies									
	USA Benefits Zone 1		**Worldwide Benefits Zone 1 & 2**	**USA Benefits Zone 1**		**Worldwide Benefits Zone 1 & 2**	**USA Benefits Zone 1**		**Worldwide Benefits Zone 1 & 2**
	EHIM In-Network Pharmacy	Out-of-Network		EHIM In-Network Pharmacy	Out-of-Network		EHIM In-Network Pharmacy	Out-of-Network	
• Generic Medications only • Not subject to Deductible or Out-of-Pocket Maximum	20%	Not covered	No Coinsurance	20%	Not covered	No Coinsurance	20%	Not covered	No Coinsurance
Evacuation & Repatriation									
Emergency Medical Evacuation* (transportation to the nearest Facility if the Treatment needed is not available locally)	Paid in full up to $50,000 per Insured Person, per Policy Year		Paid in full up to $50,000 per Insured Person, per Policy Year	Paid in full up to $50,000 per Insured Person, per Policy Year		Paid in full up to $50,000 per Insured Person, per Policy Year	Paid in full up to $50,000 per Insured Person, per Policy Year		Paid in full up to $50,000 per Insured Person, per Policy Year
Repatriation of Mortal Remains* (transportation cost and cost for burial or cremation)	No Coinsurance Maximum Benefit $15,000		No Coinsurance Maximum Benefit $15,000	No Coinsurance Maximum Benefit $15,000		No Coinsurance Maximum Benefit $15,000	No Coinsurance Maximum Benefit $15,000		No Coinsurance Maximum Benefit $15,000

**Pre-Authorization Required*

Expat Diamond Member Responsibility	1000			2000			5000		
Limit & Cost Sharing	**In-Network**	**Out-of-Network**	**Worldwide**	**In-Network**	**Out-of-Network**	**Worldwide**	**In-Network**	**Out-of-Network**	**Worldwide**
Deductible	$1,000 – Individual $2,000 – Family	$1,000 – Individual $2,000 – Family	$1,000 – Individual $2,000 – Family	$2,000 – Individual $4,000 – Family	$2,000 – Individual $4,000 – Family	$2,000 – Individual $4,000 – Family	$5,000 – Individual $10,000 – Family	$5,000 – Individual $10,000 – Family	$5,000 – Individual $10,000 – Family
In-Network Coinsurance (You Pay)	0%	N/A	0%	0%	N/A	0%	0%	N/A	0%
Out-of-Network Fee Schedule	N/A	50%	N/A	N/A	50%	N/A	N/A	50%	N/A
Out-of-Pocket Maximum	$1,000 – Individual $2,000 – Family	Unlimited Individual and Family	$1,000 – Individual $2,000 – Family	$2,000 – Individual $4,000 – Family	Unlimited Individual and Family	$2,000 – Individual $4,000 – Family	$5,000 – Individual $10,000 – Family	Unlimited Individual and Family	$5,000 – Individual $10,000 – Family
Expat Diamond What Your Plan Pays									
Maximum Annual Coverage	$3,000,000	$3,000,000	$3,000,000	$3,000,000	$3,000,000	$3,000,000	$3,000,000	$3,000,000	$3,000,000

Benefits are subject to the limitations and exclusions contained in the Policy.
All Treatments must be Medically Necessary.
Services with an asterisk must be Pre-Authorized by Plan Administrator.

Preventive Services

These Services must be performed in an In-Network Premium Care Physician's/Select Provider's office or free-standing Facility only. If Services are not performed in an In-Network Premium Care Physician's/Select Provider's office or free-standing Facility, Services will not be covered.

	USA Benefits Zone 1		Worldwide Benefits Zone 1 & 2	USA Benefits Zone 1		Worldwide Benefits Zone 1 & 2	USA Benefits Zone 1		Worldwide Benefits Zone 1 & 2
	In-Network	Out-of-Network		In-Network	Out-of-Network		In-Network	Out-of-Network	
DEDUCTIBLE DOES NOT APPLY TO THIS BENEFIT	No Coinsurance	Not covered	No Coinsurance	No Coinsurance	Not covered	No Coinsurance	No Coinsurance	Not covered	No Coinsurance
Annual Physical Examination									
Adult Annual Physical Exam includes: • CBC, lipid profile, blood glucose, urinalysis, thyroid, blood pressure measure, heart rates, weight and BMI • Papanicolaou (PAP) screening • Mammogram (eligible age: 40 years and over) • PSA screening test (eligible age: 55 years and over)									
Immunizations: Flu shot and COVID-19 vaccine only									
Child Periodic Preventative visits									
Periodic preventive services are age specific for children and babies up to 16 years of age. After 3 years of age, children should have one preventive visit per year up to age 21. Pediatric visits should follow the intervals recommended by the age specific schedule of the Pediatric Guidelines.									

Services That Require Hospitalization

Certain Services require you to use an In-Network Premium Care/Select Provider and/or free-standing Facility (as indicated below). For all other Services, we highly recommend that you use an In-Network Premium Care/Select Provider and free-standing Facility. Non-Premium Care/Select Providers and hospital affiliated Facilities, while In-Network, may be subject to excess or differentials in addition to your Cost Share amounts. Seeking care from Providers who do not participate in our Network or are Non-Network Providers typically results in greater cost to you. A search feature is available to help you find local Network Providers by using the link provided on the reverse side of your ID card or calling the telephone number also located on the reverse side of your ID card. You should always verify a Provider's participation status before you receive Services. To verify a Provider's specialty or participation status, you may contact our ConciergeCare Team or access the most recent provider directory at the provider directory online.

Pre-Admission Testing (must be performed 3-5 days in advance in a Physician's office or at a participating lab under the order of the admitting Physician)	No Coinsurance	50%	No Coinsurance	No Coinsurance	50%	No Coinsurance	No Coinsurance	50%	No Coinsurance
Inpatient Hospitalization* (room & board, Inpatient general nursing care and special diets)	No Coinsurance paid in full at average private room rate per day	50% paid in full at average private room rate per day	No Coinsurance	No Coinsurance paid in full at average private room rate per day	50% paid in full at average private room rate per day	No Coinsurance	No Coinsurance paid in full at average private room rate per day	50% paid in full at average private room rate per day	No Coinsurance
Intensive Care Unit/Telemetry/Surgical Intensive Care/Medical Intensive Care/ Trauma/Pediatric Intensive Care*	No Coinsurance (Maximum 180 days per Policy Year)	50% (Maximum 180 days per Policy Year)	No Coinsurance (Maximum 180 days per Policy Year)	No Coinsurance (Maximum 180 days per Policy Year)	50% (Maximum 180 days per Policy Year)	No Coinsurance (Maximum 180 days per Policy Year)	No Coinsurance (Maximum 180 days per Policy Year)	50% (Maximum 180 days per Policy Year)	No Coinsurance (Maximum 180 days per Policy Year)
Inpatient Mental Health* (Treatment must be provided in an accredited Psychiatric unit of a Hospital and must be under the direct control of a Psychiatric Physician)	No Coinsurance Maximum 30 day limit per Policy Year	50% Maximum 15 day limit per Policy Year	No Coinsurance Maximum 30 day limit per Policy Year	No Coinsurance Maximum 30 day limit per Policy Year	50% Maximum 15 day limit per Policy Year	No Coinsurance Maximum 30 day limit per Policy Year	No Coinsurance Maximum 30 day limit per Policy Year	50% Maximum 15 day limit per Policy Year	No Coinsurance Maximum 30 day limit per Policy Year

**Pre-Authorization Required*

Expat Diamond	1000			2000			5000		
Services That Require Hospitalization									
Certain Services require you to use an In-Network Premium Care/Select Provider and/or free-standing Facility (as indicated below). For all other Services, we highly recommend that you use an In-Network Premium Care/Select Provider and free-standing Facility. Non-Premium Care/Select Providers and hospital affiliated Facilities, while In-Network, may be subject to excess or differentials in addition to your Cost Share amounts. Seeking care from Providers who do not participate in our Network or are Non-Network Providers typically results in greater cost to you. A search feature is available to help you find local Network Providers by using the link provided on the reverse side of your ID card or calling the telephone number also located on the reverse side of your ID card. You should always verify a Provider's participation status before you receive Services. To verify a Provider's specialty or participation status, you may contact our ConciergeCare Team or access the most recent provider directory at the provider directory online.									
	USA Benefits Zone 1		**Worldwide Benefits Zone 1 & 2**	**USA Benefits Zone 1**		**Worldwide Benefits Zone 1 & 2**	**USA Benefits Zone 1**		**Worldwide Benefits Zone 1 & 2**
	In-Network	Out-of-Network		In-Network	Out-of-Network		In-Network	Out-of-Network	
Emergency Medical Services in an Emergency Room (Treatment for a sudden onset of a medical condition with Acute symptoms of sufficient severity that in the absence of immediate medical attention (or as soon as care can be made available, but not any later than 24 hours after the onset) and in the absence of which, if left untreated, could reasonably result in a significant deterioration in health) If you use an Emergency room in the Hospital for a non-emergency Service, the Services will not be covered.	No Coinsurance	50%	No Coinsurance	No Coinsurance	50%	No Coinsurance	No Coinsurance	50%	No Coinsurance
Inpatient Physician and Specialist Services	No Coinsurance (Maximum 1 specialty per day)	50% (Maximum 1 specialty per day)	No Coinsurance (Maximum 1 specialty per day)	No Coinsurance (Maximum 1 specialty per day)	50% (Maximum 1 specialty per day)	No Coinsurance (Maximum 1 specialty per day)	No Coinsurance (Maximum 1 specialty per day)	50% (Maximum 1 specialty per day)	No Coinsurance (Maximum 1 specialty per day)
Inpatient Advanced Diagnostic Services (e.g., MRI, CT scans, nuclear imaging)	No Coinsurance Maximum Benefit $3,000 per Service	50% Maximum Benefit $1,500 per Service	No Coinsurance Maximum Benefit $3,000 per Service	No Coinsurance Maximum Benefit $3,000 per Service	50% Maximum Benefit $1,500 per Service	No Coinsurance Maximum Benefit $3,000 per Service	No Coinsurance Maximum Benefit $3,000 per Service	50% Maximum Benefit $1,500 per Service	No Coinsurance Maximum Benefit $3,000 per Service
Inpatient Routine X-rays and Lab Tests (tests commonly performed while Inpatient)	No Coinsurance	50%	No Coinsurance	No Coinsurance	50%	No Coinsurance	No Coinsurance	50%	No Coinsurance
Inpatient Renal Failure Dialysis* (for Acute Renal Failure which is not the result or complication of a Chronic Condition)	No Coinsurance Maximum Benefit $30,000 per Policy Year	50% Maximum Benefit $30,000 per Policy Year	No Coinsurance Maximum Benefit $30,000 per Policy Year	No Coinsurance Maximum Benefit $30,000 per Policy Year	50% Maximum Benefit $30,000 per Policy Year	No Coinsurance Maximum Benefit $30,000 per Policy Year	No Coinsurance Maximum Benefit $30,000 per Policy Year	50% Maximum Benefit $30,000 per Policy Year	No Coinsurance Maximum Benefit $30,000 per Policy Year
Inpatient Oncology Treatment* (includes diagnostic tests, oncologist fees, radiation therapy and chemotherapy alone or in combination from the point of diagnosis and pharmaceutical treatments which have approved efficacy and market distribution) Benefits are only available when you utilize a Premium Care/Select Provider.	No Coinsurance Maximum Benefit $350,000	Not covered	No Coinsurance Maximum Benefit $350,000	No Coinsurance Maximum Benefit $350,000	Not covered	No Coinsurance Maximum Benefit $350,000	No Coinsurance Maximum Benefit $350,000	Not covered	No Coinsurance Maximum Benefit $350,000
Inpatient Reconstructive Surgery* (resulting from an Illness or Injury e.g., breast reconstruction or other bodily reconstruction due to trauma, infection, tumors or disease that will improve function and ability) Benefits are only available when you utilize a Premium Care/Select Provider.	No Coinsurance Maximum Benefit $75,000	Not covered	No Coinsurance Maximum Benefit $75,000	No Coinsurance Maximum Benefit $75,000	Not covered	No Coinsurance Maximum Benefit $75,000	No Coinsurance Maximum Benefit $75,000	Not covered	No Coinsurance Maximum Benefit $75,000
Inpatient Rehabilitation* (physical, occupational and speech therapy for the purpose of restoring the previous state of health after an Illness or Injury) Benefits are only available when you utilize a Premium Care/Select Provider.	No Coinsurance Maximum 36 day limit per Policy Year	Not covered	No Coinsurance Maximum 36 day limit per Policy Year	No Coinsurance Maximum 36 day limit per Policy Year	Not covered	No Coinsurance Maximum 36 day limit per Policy Year	No Coinsurance Maximum 36 day limit per Policy Year	Not covered	No Coinsurance Maximum 36 day limit per Policy Year
Inpatient Surgical Procedures and Surgeon Fees * • Surgeon's fees for Medically Necessary Treatments related to an Injury or Illness which are charged by the main surgeon that performed the Surgical procedure. • Some complex medical procedures may require an assistant surgeon or co-surgeon performing services. This applies only to procedures for which an assistant surgeon or co-surgeon is indicated by Medical Necessity and evidence-based medicine. Claims in the United States will be paid based on AMA guidelines for assistant surgeons and surgery reimbursements. International Claims will be paid based on UCR. • Services of an Anesthesiologist, other than the operating Surgeon or Assistant Surgeon, who administers anesthesia for a covered Surgical Procedure are also covered.	No Coinsurance	50%	No Coinsurance	No Coinsurance	50%	No Coinsurance	No Coinsurance	50%	No Coinsurance

**Pre-Authorization Required*

Expat Diamond	1000			2000			5000		
Services That Require Hospitalization									
Certain Services require you to use an In-Network Premium Care/Select Provider and/or free-standing Facility (as indicated below). For all other Services, we highly recommend that you use an In-Network Premium Care/Select Provider and free-standing Facility. Non-Premium Care/Select Providers and hospital affiliated Facilities, while In-Network, may be subject to excess or differentials in addition to your Cost Share amounts. Seeking care from Providers who do not participate in our Network or are Non-Network Providers typically results in greater cost to you. A search feature is available to help you find local Network Providers by using the link provided on the reverse side of your ID card or calling the telephone number also located on the reverse side of your ID card. You should always verify a Provider's participation status before you receive Services. To verify a Provider's specialty or participation status, you may contact our ConciergeCare Team or access the most recent provider directory at the provider directory online.									
	USA Benefits Zone 1		**Worldwide Benefits Zone 1 & 2**	**USA Benefits Zone 1**		**Worldwide Benefits Zone 1 & 2**	**USA Benefits Zone 1**		**Worldwide Benefits Zone 1 & 2**
	In-Network	Out-of-Network		In-Network	Out-of-Network		In-Network	Out-of-Network	
Inpatient Surgical Appliances and Prosthesis (covered for prosthetic, surgical, orthopedic and cardiac Procedures which are an integral part of the Surgical Procedure) Please refer to your Policy for a list of devices, appliances or prostheses that may be excluded.	No Coinsurance	50%	No Coinsurance	No Coinsurance	50%	No Coinsurance	No Coinsurance	50%	No Coinsurance
Organ Transplant* • Includes heart, heart and lung, kidney, kidney and pancreas, liver, cornea, bone and skin grafts, small intestines and allogenic and autologous, bone marrow (refer to your Policy for coverage of approved Diagnosis), blood and stem cell transplants. Benefits are only available when you utilize a Premium Care/Select Provider.	No Coinsurance Maximum Benefit $60,000 Lifetime	Not covered	No Coinsurance Maximum Benefit $60,000 Lifetime	No Coinsurance Maximum Benefit $60,000 Lifetime	Not covered	No Coinsurance Maximum Benefit $60,000 Lifetime	No Coinsurance Maximum Benefit $60,000 Lifetime	Not covered	No Coinsurance Maximum Benefit $60,000 Lifetime
Emergency Ground Ambulance (limited to one way trip when responding to a medical Emergency where other means of transportation will endanger the patient life or special medical equipment must be used en route to the closest medical Facility available to treat the emergency that results in an Inpatient Admission)	No Coinsurance	No Coinsurance	No Coinsurance	No Coinsurance	No Coinsurance	No Coinsurance	No Coinsurance	No Coinsurance	No Coinsurance
Outpatient Care									
Certain Services require you to use an In-Network Premium Care/Select Provider and/or free-standing Facility (as indicated below). For all other Services, we highly recommend that you use an In-Network Premium Care/Select Provider and/or free-standing Facility. Non-Premium Care/Select Providers and hospital affiliated Facilities, while In-Network, may be subject to excess or differentials in addition to your Cost Share amounts. Seeking care from Providers who do not participate in our Network or are Non-Network Providers typically results in greater cost to you. You should always verify a Provider's participation status before you receive Services. To verify a Provider's specialty or participation status, you may contact our ConciergeCare Team or access the most recent provider directory at the provider directory online. 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.									
Urgent Care Clinic / Facility	No Coinsurance	50%	No Coinsurance	No Coinsurance	50%	No Coinsurance	No Coinsurance	50%	No Coinsurance
Outpatient Ambulatory Surgical Facility & Surgical Care* • Surgeon's fees for Medically Necessary Treatments related to an Injury or Illness which are charged by the main surgeon that performed the Surgical procedure. • Some complex medical procedures may require an assistant surgeon or co-surgeon performing services. This applies only to procedures for which an assistant surgeon or co-surgeon is indicated by Medical Necessity and evidence-based medicine. Claims in the United States will be paid based on AMA guidelines for assistant surgeons and surgery reimbursements. International Claims will be paid based on UCR. • Services of an Anesthesiologist, other than the operating Surgeon or Assistant Surgeon, who administers anesthesia for a covered Surgical Procedure are also covered.	No Coinsurance	50%	No Coinsurance	No Coinsurance	50%	No Coinsurance	No Coinsurance	50%	No Coinsurance
Routine X-rays and Laboratory Tests Benefits are only available when performed in a Premium Care Physician/Select Provider's office or in a free-standing non-hospital Facility.	No Coinsurance	Not covered	No Coinsurance	No Coinsurance	Not covered	No Coinsurance	No Coinsurance	Not covered	No Coinsurance
Advanced Diagnostic and Interventional Radiology Services* Benefits are only available when performed in a Premium Care Physician/Select Provider's office or in a free-standing non-hospital Facility.	No Coinsurance Maximum Benefit $4,000 per Policy Year	Not covered	No Coinsurance Maximum Benefit $4,000 per Policy Year	No Coinsurance Maximum Benefit $4,000 per Policy Year	Not covered	No Coinsurance Maximum Benefit $4,000 per Policy Year	No Coinsurance Maximum Benefit $4,000 per Policy Year	Not covered	No Coinsurance Maximum Benefit $4,000 per Policy Year

**Pre-Authorization Required*

Expat Diamond	1000			2000			5000		
Outpatient Care									
Certain Services require you to use an In-Network Premium Care/Select Provider and/or free-standing Facility (as indicated below). For all other Services, we highly recommend that you use an In-Network Premium Care/Select Provider and/or free-standing Facility. Non-Premium Care/Select Providers and hospital affiliated Facilities, while In-Network, may be subject to excess or differentials in addition to your Cost Share amounts. Seeking care from Providers who do not participate in our Network or are Non-Network Providers typically results in greater cost to you. You should always verify a Provider's participation status before you receive Services. To verify a Provider's specialty or participation status, you may contact our ConciergeCare Team or access the most recent provider directory at the provider directory online. 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.									
	USA Benefits Zone 1		**Worldwide Benefits Zone 1 & 2**	**USA Benefits Zone 1**		**Worldwide Benefits Zone 1 & 2**	**USA Benefits Zone 1**		**Worldwide Benefits Zone 1 & 2**
	In-Network	Out-of-Network		In-Network	Out-of-Network		In-Network	Out-of-Network	
Outpatient Therapeutic Services Combined (physical, occupational and speech therapy for the purpose of restoring the previous state of health after an Illness or Injury)	No Coinsurance Maximum allowance $150 per session, Maximum 36 sessions per Policy Year	Not covered	No Coinsurance Maximum allowance $150 per session, Maximum 36 sessions per Policy Year	No Coinsurance Maximum allowance $150 per session, Maximum 36 sessions per Policy Year	Not covered	No Coinsurance Maximum allowance $150 per session, Maximum 36 sessions per Policy Year	No Coinsurance Maximum allowance $150 per session, Maximum 36 sessions per Policy Year	Not covered	No Coinsurance Maximum allowance $150 per session, Maximum 36 sessions per Policy Year
Outpatient Renal Failure Dialysis* (for Acute Renal Failure which is not the result or complication of a Chronic Condition)	No Coinsurance Maximum Benefit $100,000 limit per Policy Year	Not covered	No Coinsurance Maximum Benefit $100,000 limit per Policy Year	No Coinsurance Maximum Benefit $100,000 limit per Policy Year	Not covered	No Coinsurance Maximum Benefit $100,000 limit per Policy Year	No Coinsurance Maximum Benefit $100,000 limit per Policy Year	Not covered	No Coinsurance Maximum Benefit $100,000 limit per Policy Year
Outpatient Oncology Treatment* (includes diagnostic tests, oncologist fees, radiation therapy and chemotherapy alone or in combination from the point of diagnosis and pharmaceutical treatments which have approved efficacy and market distribution) Benefits are only available when you utilize a Premium Care/Select Provider.	No Coinsurance Maximum Benefit $350,000 per Policy Year	50% Maximum Benefit $100,000 per Policy Year	No Coinsurance Maximum Benefit $350,000 per Policy Year	No Coinsurance Maximum Benefit $350,000 per Policy Year	50% Maximum Benefit $100,000 per Policy Year	No Coinsurance Maximum Benefit $350,000 per Policy Year	No Coinsurance Maximum Benefit $350,000 per Policy Year	50% Maximum Benefit $100,000 per Policy Year	No Coinsurance Maximum Benefit $350,000 per Policy Year
Outpatient 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). Benefits are only available when you utilize a Premium Care/Select Provider.	No Coinsurance Maximum Benefit $75,000 per Policy Year	Not covered	No Coinsurance Maximum Benefit $75,000 per Policy Year	No Coinsurance Maximum Benefit $75,000 per Policy Year	Not covered	No Coinsurance Maximum Benefit $75,000 per Policy Year	No Coinsurance Maximum Benefit $75,000 per Policy Year	Not covered	No Coinsurance Maximum Benefit $75,000 per Policy Year
Outpatient Emergency Dental Treatment (due to Accident or Injury and resulting in damage to Sound Natural Tooth and treated within 24 hours of the Emergency event)	No Coinsurance Maximum Benefit $300 per tooth up to $1,500 per Policy Year	Not covered	No Coinsurance Maximum Benefit $300 per tooth up to $1,500 per Policy Year	No Coinsurance Maximum Benefit $300 per tooth up to $1,500 per Policy Year	Not covered	No Coinsurance Maximum Benefit $300 per tooth up to $1,500 per Policy Year	No Coinsurance Maximum Benefit $300 per tooth up to $1,500 per Policy Year	Not covered	No Coinsurance Maximum Benefit $300 per tooth up to $1,500 per Policy Year
Home Health Care* (care must begin immediately following your Hospital stay of no less than 3 days, ordered by a Physician and provided under the supervision of a registered nurse)	No Coinsurance Maximum 90 days per Policy Year	Not covered	No Coinsurance Maximum 90 days per Policy Year	No Coinsurance Maximum 90 days per Policy Year	Not covered	No Coinsurance Maximum 90 days per Policy Year	No Coinsurance Maximum 90 days per Policy Year	Not covered	No Coinsurance Maximum 90 days per Policy Year
Hospice or Palliative Care* (accommodation, nursing care and support for the Treatment of end-of-life stages)	No Coinsurance Maximum Benefit $25,000 or 90 days per Policy Year, whichever occurs first	Not covered	No Coinsurance Maximum Benefit $25,000 or 90 days per Policy Year, whichever occurs first	No Coinsurance Maximum Benefit $25,000 or 90 days per Policy Year, whichever occurs first	Not covered	No Coinsurance Maximum Benefit $25,000 or 90 days per Policy Year, whichever occurs first	No Coinsurance Maximum Benefit $25,000 or 90 days per Policy Year, whichever occurs first	Not covered	No Coinsurance Maximum Benefit $25,000 or 90 days per Policy Year, whichever occurs first
Durable Medical Equipment (helps to complete your daily activities e.g., walker, wheelchair, oxygen device or other equipment that can withstand repeated use which must be prescribed by a Physician)	No Coinsurance Maximum Benefit $3,000 per Policy Year	Not covered	No Coinsurance Maximum Benefit $3,000 per Policy Year	No Coinsurance Maximum Benefit $3,000 per Policy Year	Not covered	No Coinsurance Maximum Benefit $3,000 per Policy Year	No Coinsurance Maximum Benefit $3,000 per Policy Year	Not covered	No Coinsurance Maximum Benefit $3,000 per Policy Year
Physician Services									
Certain Services require you to use an In-Network Premium Care/Select Provider and/or free-standing Facility (as indicated below). For all other Services, we highly recommend that you use an In-Network Premium Care/Select Provider and/or free-standing Facility. Non-Premium Care/Select Providers and hospital affiliated Facilities, while In-Network, may be subject to excess or differentials in addition to your Cost Share amounts. Seeking care from Providers who do not participate in our Network or are Non-Network Providers typically results in greater cost to you. You should always verify a Provider's participation status before you receive Services. To verify a Provider's specialty or participation status, you may contact our ConciergeCare Team or access the most recent provider directory at the provider directory online.									
Telemedicine Consultations and Visits (for Illnesses including cold & flu Symptoms, allergies, pink eye, respiratory infection, sinus problems and skin problems)	No Co-payment Maximum 8 consults per Policy Year		only available in the USA	No Co-payment Maximum 8 consults per Policy Year		only available in the USA	No Co-payment Maximum 8 consults per Policy Year		only available in the USA
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)	No Coinsurance Maximum allowance $250 per visit	50% Maximum allowance $125 per visit	No Coinsurance Maximum allowance $250 per visit	No Coinsurance Maximum allowance $250 per visit	50% Maximum allowance $125 per visit	No Coinsurance Maximum allowance $250 per visit	No Coinsurance Maximum allowance $250 per visit	50% Maximum allowance $125 per visit	No Coinsurance Maximum allowance $250 per visit

**Pre-Authorization Required*

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Physician Services

Certain Services require you to use an In-Network Premium Care/Select Provider and/or free-standing Facility (as indicated below). For all other Services, we highly recommend that you use an In-Network Premium Care/Select Provider and/or free-standing Facility. Non-Premium Care/Select Providers and hospital affiliated Facilities, while In-Network, may be subject to excess or differentials in addition to your Cost Share amounts. Seeking care from Providers who do not participate in our Network or are Non-Network Providers typically results in greater cost to you. You should always verify a Provider's participation status before you receive Services. To verify a Provider's specialty or participation status, you may contact our ConciergeCare Team or access the most recent provider directory at the provider directory online.

	USA Benefits Zone 1		Worldwide Benefits Zone 1 & 2	USA Benefits Zone 1		Worldwide Benefits Zone 1 & 2	USA Benefits Zone 1		Worldwide Benefits Zone 1 & 2
	In-Network	Out-of-Network		In-Network	Out-of-Network		In-Network	Out-of-Network	
Primary Care Visit (includes Physicians, general or Family practitioner and gynecologist, when designated as the Primary Care Physician who provides the first contact for an individual with an undiagnosed health issue) Benefits are only available when you utilize a Premium Care/Select Provider.	No Coinsurance Maximum allowance $250 per visit	Not covered	No Coinsurance Maximum allowance $250 per visit	No Coinsurance Maximum allowance $250 per visit	Not covered	No Coinsurance Maximum allowance $250 per visit	No Coinsurance Maximum allowance $250 per visit	Not covered	No Coinsurance Maximum allowance $250 per visit
Specialist Visit • When medically indicated • When your medical condition or Diagnosis requires that you are treated by a Physician with specific training for your condition or Diagnosis Benefits are only available when you utilize a Premium Care/Select Provider.	No Coinsurance Maximum allowance $400 per visit	Not covered	No Coinsurance Maximum allowance $400 per visit	No Coinsurance Maximum allowance $400 per visit	Not covered	No Coinsurance Maximum allowance $400 per visit	No Coinsurance Maximum allowance $400 per visit	Not covered	No Coinsurance Maximum allowance $400 per visit
Outpatient Mental Health Visit (Treatment must be provided via e-visit or in a Physician's office under the direct control of a Psychiatric Physician)	No Coinsurance Maximum 25 visits per Policy Year	50% Maximum 15 visits per Policy Year	No Coinsurance Maximum 25 visits per Policy Year	No Coinsurance Maximum 25 visits per Policy Year	50% Maximum 15 visits per Policy Year	No Coinsurance Maximum 25 visits per Policy Year	No Coinsurance Maximum 25 visits per Policy Year	50% Maximum 15 visits per Policy Year	No Coinsurance Maximum 25 visits per Policy Year
Alternative Medicine (acupuncture, chiropractic, homeopathy only)	No Coinsurance Maximum allowance $200 per session Combined Maximum 5 visits per Policy Year	Not covered	No Coinsurance Maximum allowance $200 per session Combined Maximum 5 visits per Policy Year	No Coinsurance Maximum allowance $200 per session Combined Maximum 5 visits per Policy Year	Not covered	No Coinsurance Maximum allowance $200 per session Combined Maximum 5 visits per Policy Year	No Coinsurance Maximum allowance $200 per session Combined Maximum 5 visits per Policy Year	Not covered	No Coinsurance Maximum allowance $200 per session Combined Maximum 5 visits per Policy Year
Podiatry (Treatment for bursitis, heel spur, plantar fasciitis, ingrown toenail, infections, warts (including plantar warts), and fungal infections) Routine foot care and any Surgery of the foot are not covered under this benefit.	No Coinsurance Maximum allowance $300 per session Maximum 12 visits per Policy Year	Not covered	No Coinsurance Maximum allowance $300 per session Maximum 12 visits per Policy Year	No Coinsurance Maximum allowance $300 per session Maximum 12 visits per Policy Year	Not covered	No Coinsurance Maximum allowance $300 per session Maximum 12 visits per Policy Year	No Coinsurance Maximum allowance $300 per session Maximum 12 visits per Policy Year	Not covered	No Coinsurance Maximum allowance $300 per session Maximum 12 visits per Policy Year
Allergy Testing & Treatment* (includes injections for allergies, may include desensitization therapy and the cost of hypo-sensitization serum) Benefits are only available when you utilize a Premium Care/Select Provider.	No Coinsurance	50% Maximum Benefit $500 per Policy Year	No Coinsurance	No Coinsurance	50% Maximum Benefit $500 per Policy Year	No Coinsurance	No Coinsurance	50% Maximum Benefit $500 per Policy Year	No Coinsurance

Outpatient Prescription Drugs and Supplies

	USA Benefits Zone 1		Worldwide Benefits Zone 1 & 2	USA Benefits Zone 1		Worldwide Benefits Zone 1 & 2	USA Benefits Zone 1		Worldwide Benefits Zone 1 & 2
	EHIM In-Network Pharmacy	Out-of-Network		EHIM In-Network Pharmacy	Out-of-Network		EHIM In-Network Pharmacy	Out-of-Network	
• Generic Medications only • Not subject to Deductible or Out-of-Pocket Maximum	No Coinsurance	Not covered	No Coinsurance	No Coinsurance	Not covered	No Coinsurance	No Coinsurance	Not covered	No Coinsurance

Evacuation & Repatriation

Emergency Medical Evacuation* (transportation to the nearest Facility if the Treatment needed is not available locally)	Paid in full up to $75,000 per Insured Person, per Policy Year		Paid in full up to $75,000 per Insured Person, per Policy Year	Paid in full up to $75,000 per Insured Person, per Policy Year		Paid in full up to $75,000 per Insured Person, per Policy Year	Paid in full up to $75,000 per Insured Person, per Policy Year		Paid in full up to $75,000 per Insured Person, per Policy Year
Repatriation of Mortal Remains* (transportation cost and cost for burial or cremation)	No Coinsurance Maximum Benefit $25,000		No Coinsurance Maximum Benefit $25,000	No Coinsurance Maximum Benefit $25,000		No Coinsurance Maximum Benefit $25,000	No Coinsurance Maximum Benefit $25,000		No Coinsurance Maximum Benefit $25,000

**Pre-Authorization Required*

Expat Plus
Member Responsibility

Limit & Cost Sharing	In-Network	Out-of-Network	Worldwide
Deductible	$0 – Individual $0 – Family	$1,000 – Individual $2,000 – Family	$1,000 – Individual $2,000 – Family
In-Network Coinsurance (You Pay)	0%	N/A	0%
Out-of-Network Fee Schedule	N/A	50%	N/A
Out-of-Pocket Maximum	N/A	Unlimited Individual and Family	$1,000 – Individual $2,000 – Family

Expat Plus What Your Plan Pays

Maximum Annual Coverage	$3,000,000	$3,000,000	$3,000,000

Benefits are subject to the limitations and exclusions contained in the Policy.
All Treatments must be Medically Necessary.
Services with an asterisk must be Pre-Authorized by Plan Administrator.

Preventive Services

These Services must be performed in an In-Network Premium Care Physician's/Select Provider's office or free-standing Facility only. If Services are not performed in an In-Network Premium Care Physician's/Select Provider's office or free-standing Facility, Services will not be covered.

	USA Benefits Zone 1		**Worldwide Benefits Zone 1 & 2**
	In-Network	Out-of-Network	
Annual Physical Examination	No Coinsurance	Not covered	No Coinsurance
Adult Annual Physical Exam includes: • CBC, lipid profile, blood glucose, urinalysis, thyroid, blood pressure measure, heart rates, weight and BMI • Papanicolaou (PAP) screening • Mammogram (eligible age: 40 years and over) • PSA screening test (eligible age: 55 years and over)			
Immunizations: Flu shot and COVID-19 vaccine only			
Child Periodic Preventative visits			
Periodic preventive services are age specific for children and babies up to 16 years of age. After 3 years of age, children should have one preventive visit per year up to age 21. Pediatric visits should follow the intervals recommended by the age specific schedule of the Pediatric Guidelines.			

Services That Require Hospitalization

Certain Services require you to use an In-Network Premium Care/Select Provider and/or free-standing Facility (as indicated below). For all other Services, we highly recommend that you use an In-Network Premium Care/Select Provider and free-standing Facility. Non-Premium Care/Select Providers and hospital affiliated Facilities, while In-Network, may be subject to excess or differentials in addition to your Cost Share amounts. Seeking care from Providers who do not participate in our Network or are Non-Network Providers typically results in greater cost to you. A search feature is available to help you find local Network Providers by using the link provided on the reverse side of your ID card or calling the telephone number also located on the reverse side of your ID card. You should always verify a Provider's participation status before you receive Services. To verify a Provider's specialty or participation status, you may contact our ConciergeCare Team or access the most recent provider directory at the provider directory online.

Pre-Admission Testing (must be performed 3-5 days in advance in a Physician's office or at a participating lab under the order of the admitting Physician)	No Coinsurance	50%	No Coinsurance
Inpatient Hospitalization* (room & board, Inpatient general nursing care and special diets)	No Coinsurance paid in full at average private room rate per day	50% paid in full at average private room rate per day	No Coinsurance
Intensive Care Unit/Telemetry/Surgical Intensive Care/Medical Intensive Care/Trauma/Pediatric Intensive Care*	No Coinsurance (Maximum 180 days per Policy Year)	50% (Maximum 180 days per Policy Year)	No Coinsurance (Maximum 180 days per Policy Year)
Inpatient Mental Health* (Treatment must be provided in an accredited Psychiatric unit of a Hospital and must be under the direct control of a Psychiatric Physician)	No Coinsurance Maximum 30 day limit per Policy Year	50% Maximum 15 day limit per Policy Year	No Coinsurance Maximum 30 day limit per Policy Year
Emergency Medical Services in an Emergency Room (Treatment for a sudden onset of a medical condition with Acute symptoms of sufficient severity that in the absence of immediate medical attention (or as soon as care can be made available, but not any later than 24 hours after the onset) and in the absence of which, if left untreated, could reasonably result in a significant deterioration in health) If you use an Emergency room in the Hospital for a non-emergency Service, the Services will not be covered.	No Coinsurance	50%	No Coinsurance

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Services That Require Hospitalization

Certain Services require you to use an In-Network Premium Care/Select Provider and/or free-standing Facility (as indicated below). For all other Services, we highly recommend that you use an In-Network Premium Care/Select Provider and free-standing Facility. Non-Premium Care/Select Providers and hospital affiliated Facilities, while In-Network, may be subject to excess or differentials in addition to your Cost Share amounts. Seeking care from Providers who do not participate in our Network or are Non-Network Providers typically results in greater cost to you. A search feature is available to help you find local Network Providers by using the link provided on the reverse side of your ID card or calling the telephone number also located on the reverse side of your ID card. You should always verify a Provider's participation status before you receive Services. To verify a Provider's specialty or participation status, you may contact our ConciergeCare Team or access the most recent provider directory at the provider directory online.

	USA Benefits Zone 1		**Worldwide Benefits Zone 1 & 2**
	In-Network	Out-of-Network	
Inpatient Physician and Specialist Services	No Coinsurance (Maximum 1 specialty per day)	50% (Maximum 1 specialty per day)	No Coinsurance (Maximum 1 specialty per day)
Inpatient Advanced Diagnostic Services (e.g., MRI, CT scans, nuclear imaging)	No Coinsurance Maximum Benefit $3,000 per Service	50% Maximum Benefit $1,500 per Service	No Coinsurance Maximum Benefit $3,000 per Service
Inpatient Routine X-rays and Lab Tests (tests commonly performed while Inpatient)	No Coinsurance	50%	No Coinsurance
Inpatient Renal Failure Dialysis* (for Acute Renal Failure which is not the result or complication of a Chronic Condition)	No Coinsurance Maximum Benefit $30,000 per Policy Year	50% Maximum Benefit $30,000 per Policy Year	No Coinsurance Maximum Benefit $30,000 per Policy Year
Inpatient Oncology Treatment* (includes diagnostic tests, oncologist fees, radiation therapy and chemotherapy alone or in combination from the point of diagnosis and pharmaceutical treatments which have approved efficacy and market distribution) Benefits are only available when you utilize a Premium Care/Select Provider.	No Coinsurance Maximum Benefit $350,000	Not covered	No Coinsurance Maximum Benefit $350,000
Inpatient Reconstructive Surgery* (resulting from an Illness or Injury e.g., breast reconstruction or other bodily reconstruction due to trauma, infection, tumors or disease that will improve function and ability) Benefits are only available when you utilize a Premium Care/Select Provider.	No Coinsurance Maximum Benefit $75,000	Not covered	No Coinsurance Maximum Benefit $75,000
Inpatient Rehabilitation* (physical, occupational and speech therapy for the purpose of restoring the previous state of health after an Illness or Injury) Benefits are only available when you utilize a Premium Care/Select Provider.	No Coinsurance Maximum 36 day limit per Policy Year	Not covered	No Coinsurance Maximum 36 day limit per Policy Year
Inpatient Surgical Procedures and Surgeon Fees * • Surgeon's fees for Medically Necessary Treatments related to an Injury or Illness which are charged by the main surgeon that performed the Surgical procedure. • Some complex medical procedures may require an assistant surgeon or co-surgeon performing services. This applies only to procedures for which an assistant surgeon or co-surgeon is indicated by Medical Necessity and evidence-based medicine. Claims in the United States will be paid based on AMA guidelines for assistant surgeons and surgery reimbursements. International Claims will be paid based on UCR. • Services of an Anesthesiologist, other than the operating Surgeon or Assistant Surgeon, who administers anesthesia for a covered Surgical Procedure are also covered.	No Coinsurance	50%	No Coinsurance
Inpatient Surgical Appliances and Prosthesis (covered for prosthetic, surgical, orthopedic and cardiac Procedures which are an integral part of the Surgical Procedure) Please refer to your Policy for a list of devices, appliances or prostheses that may be excluded.	No Coinsurance	50%	No Coinsurance
Organ Transplant* • Includes heart, heart and lung, kidney, kidney and pancreas, liver, cornea, bone and skin grafts, small intestines and allogenic and autologous, bone marrow (refer to your Policy for coverage of approved Diagnosis), blood and stem cell transplants. Benefits are only available when you utilize a Premium Care/Select Provider.	No Coinsurance Maximum Benefit $60,000 Lifetime	Not covered	No Coinsurance Maximum Benefit $60,000 Lifetime
Emergency Ground Ambulance (limited to one way trip when responding to a medical Emergency where other means of transportation will endanger the patient life or special medical equipment must be used en route to the closest medical Facility available to treat the emergency that results in an Inpatient Admission)	No Coinsurance	No Coinsurance	No Coinsurance

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Outpatient Care

Certain Services require you to use an In-Network Premium Care/Select Provider and/or free-standing Facility (as indicated below). For all other Services, we highly recommend that you use an In-Network Premium Care/Select Provider and/or free-standing Facility. Non-Premium Care/Select Providers and hospital affiliated Facilities, while In-Network, may be subject to excess or differentials in addition to your Cost Share amounts. Seeking care from Providers who do not participate in our Network or are Non-Network Providers typically results in greater cost to you. You should always verify a Provider's participation status before you receive Services. To verify a Provider's specialty or participation status, you may contact our ConciergeCare Team or access the most recent provider directory at the provider directory online. 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.

	USA Benefits Zone 1		**Worldwide Benefits Zone 1 & 2**
	In-Network	Out-of-Network	
Urgent Care Clinic / Facility	No Coinsurance	50%	No Coinsurance
Outpatient Ambulatory Surgical Facility & Surgical Care* • Surgeon's fees for Medically Necessary Treatments related to an Injury or Illness which are charged by the main surgeon that performed the Surgical procedure. • Some complex medical procedures may require an assistant surgeon or co-surgeon performing services. This applies only to procedures for which an assistant surgeon or co-surgeon is indicated by Medical Necessity and evidence-based medicine. Claims in the United States will be paid based on AMA guidelines for assistant surgeons and surgery reimbursements. International Claims will be paid based on UCR. • Services of an Anesthesiologist, other than the operating Surgeon or Assistant Surgeon, who administers anesthesia for a covered Surgical Procedure are also covered.	No Coinsurance	50%	No Coinsurance
Routine X-rays and Laboratory Tests Benefits are only available when performed in a Premium Care Physician/Select Provider's office or in a free-standing non-hospital Facility.	No Coinsurance	Not covered	No Coinsurance
Advanced Diagnostic and Interventional Radiology Services* Benefits are only available when performed in a Premium Care Physician/Select Provider's office or in a free-standing non-hospital Facility.	No Coinsurance Maximum Benefit $4,000 per Policy Year	Not covered	No Coinsurance Maximum Benefit $4,000 per Policy Year
Outpatient Therapeutic Services Combined (physical, occupational and speech therapy for the purpose of restoring the previous state of health after an Illness or Injury)	No Coinsurance Maximum allowance $150 per session, Maximum 36 sessions per Policy Year	Not covered	No Coinsurance Maximum allowance $150 per session, Maximum 36 sessions per Policy Year
Outpatient Renal Failure Dialysis* (for Acute Renal Failure which is not the result or complication of a Chronic Condition)	No Coinsurance Maximum Benefit $100,000 limit per Policy Year	Not covered	No Coinsurance Maximum Benefit $100,000 limit per Policy Year
Outpatient Oncology Treatment* (includes diagnostic tests, oncologist fees, radiation therapy and chemotherapy alone or in combination from the point of diagnosis and pharmaceutical treatments which have approved efficacy and market distribution) Benefits are only available when you utilize a Premium Care/Select Provider.	No Coinsurance Maximum Benefit $350,000 per Policy Year	50% Maximum Benefit $100,000 per Policy Year	No Coinsurance Maximum Benefit $350,000 per Policy Year
Outpatient 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). Benefits are only available when you utilize a Premium Care/Select Provider.	No Coinsurance Maximum Benefit $75,000 per Policy Year	Not covered	No Coinsurance Maximum Benefit $75,000 per Policy Year
Outpatient Emergency Dental Treatment (due to Accident or Injury and resulting in damage to Sound Natural Tooth and treated within 24 hours of the Emergency event)	No Coinsurance Maximum Benefit $300 per tooth up to $1,500 per Policy Year	Not covered	No Coinsurance Maximum Benefit $300 per tooth up to $1,500 per Policy Year
Home Health Care* (care must begin immediately following your Hospital stay of no less than 3 days, ordered by a Physician and provided under the supervision of a registered nurse)	No Coinsurance Maximum 90 days per Policy Year	Not covered	No Coinsurance Maximum 90 days per Policy Year
Hospice or Palliative Care* (accommodation, nursing care and support for the Treatment of end-of-life stages)	No Coinsurance Maximum Benefit $25,000 or 90 days per Policy Year, whichever occurs first	Not covered	No Coinsurance Maximum Benefit $25,000 or 90 days per Policy Year, whichever occurs first
Durable Medical Equipment (helps to complete your daily activities e.g., walker, wheelchair, oxygen device or other equipment that can withstand repeated use which must be prescribed by a Physician)	No Coinsurance Maximum Benefit $3,000 per Policy Year	Not covered	No Coinsurance Maximum Benefit $3,000 per Policy Year

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Physician Services

Certain Services require you to use an In-Network Premium Care/Select Provider and/or free-standing Facility (as indicated below). For all other Services, we highly recommend that you use an In-Network Premium Care/Select Provider and/or free-standing Facility. Non-Premium Care/Select Providers and hospital affiliated Facilities, while In-Network, may be subject to excess or differentials in addition to your Cost Share amounts. Seeking care from Providers who do not participate in our Network or are Non-Network Providers typically results in greater cost to you. You should always verify a Provider's participation status before you receive Services. To verify a Provider's specialty or participation status, you may contact our ConciergeCare Team or access the most recent provider directory at the provider directory online.

	USA Benefits Zone 1		**Worldwide Benefits Zone 1 & 2**
	In-Network	Out-of-Network	
Telemedicine Consultations and Visits (for Illnesses including cold & flu Symptoms, allergies, pink eye, respiratory infection, sinus problems and skin problems)	No Co-payment Maximum 8 consults per Policy Year		only available in the USA
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)	No Coinsurance Maximum allowance $250 per visit	50% Maximum allowance $125 per visit	No Coinsurance Maximum allowance $250 per visit
Primary Care Visit (includes Physicians, general or Family practitioner and gynecologist, when designated as the Primary Care Physician who provides the first contact for an individual with an undiagnosed health issue) Benefits are only available when you utilize a Premium Care/Select Provider.	No Coinsurance Maximum allowance $250 per visit	Not covered	No Coinsurance Maximum allowance $250 per visit
Specialist Visit • When medically indicated • When your medical condition or Diagnosis requires that you are treated by a Physician with specific training for your condition or Diagnosis Benefits are only available when you utilize a Premium Care/Select Provider.	No Coinsurance Maximum allowance $400 per visit	Not covered	No Coinsurance Maximum allowance $400 per visit
Outpatient Mental Health Visit (Treatment must be provided via e-visit or in a Physician's office under the direct control of a Psychiatric Physician)	No Coinsurance Maximum 25 visits per Policy Year	50% Maximum 15 visits per Policy Year	No Coinsurance Maximum 25 visits per Policy Year
Alternative Medicine (acupuncture, chiropractic, homeopathy only)	No Coinsurance Maximum allowance $200 per session Combined Maximum 5 visits per Policy Year	Not covered	No Coinsurance Maximum allowance $200 per session Combined Maximum 5 visits per Policy Year
Podiatry (Treatment for bursitis, heel spur, plantar fasciitis, ingrown toenail, infections, warts (including plantar warts), and fungal infections) Routine foot care and any Surgery of the foot are not covered under this benefit.	No Coinsurance Maximum allowance $300 per session Maximum 12 visits per Policy Year	Not covered	No Coinsurance Maximum allowance $300 per session Maximum 12 visits per Policy Year
Allergy Testing & Treatment* (includes injections for allergies, may include desensitization therapy and the cost of hypo-sensitization serum) Benefits are only available when you utilize a Premium Care/Select Provider.	No Coinsurance	50% Maximum Benefit $500 per Policy Year	No Coinsurance

Outpatient Prescription Drugs and Supplies

	USA Benefits Zone 1		**Worldwide Benefits Zone 1 & 2**
	EHIM In-Network Pharmacy	Out-of-Network	
Generic Medications only	No Coinsurance	Not covered	No Coinsurance

Evacuation & Repatriation

Emergency Medical Evacuation* (transportation to the nearest Facility if the Treatment needed is not available locally)	Paid in full up to $75,000 per Insured Person, per Policy Year	Paid in full up to $75,000 per Insured Person, per Policy Year
Repatriation of Mortal Remains* (transportation cost and cost for burial or cremation)	No Coinsurance Maximum Benefit $25,000	No Coinsurance Maximum Benefit $25,000

**Pre-Authorization Required*

WellAway

Keeping You Well, While You're Away.®

UnitedHealthcare®

payerfusion®

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