



World Plans Brochure

wellaway.com

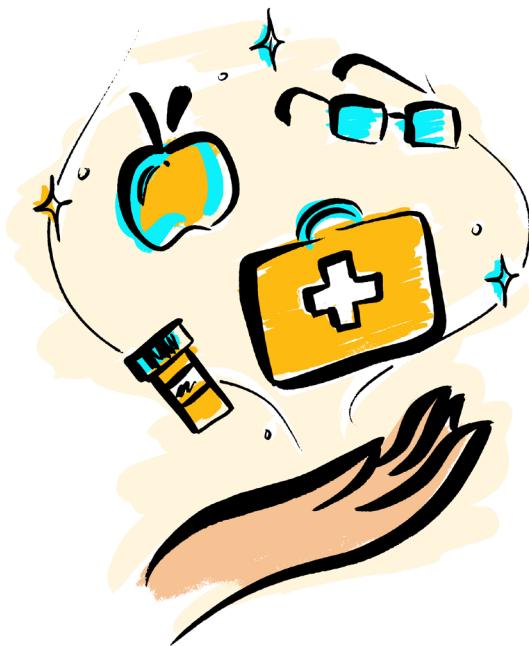
WellAway 

January 1, 2026

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.



- ✓ Emergency Medical Assistance
- ✓ Multi-Lingual Customer Service
- ✓ Telemedicine Services
- ✓ Competitive Prices
- ✓ Customizable Group Plans

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



Our Health Partner: Teladoc

Access to your doctor 24/7 (USA only)



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

- Talk to a doctor anytime, when you are in the USA.
- Receive quality care via phone, video or mobile app.
- Prompt treatment. Talk to your doctor in minutes.
- A network of doctors that can treat every member of the family.
- Prescriptions sent to pharmacy of choice if medically necessary.
- Teladoc is less expensive than the ER or urgent care.



Get The Care You Need

Teladoc doctors can treat many medical conditions, including:

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

Talk to a doctor any time! Teladoc.com 1-800-TELADOC (835-2362)



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

World Plans

An international health plan featuring annual limit options ranging from \$500,000 to \$1 million with different deductible options. The WellAway World Plans provide different levels of coverage for expatriates, including several optional benefits to choose from. Our members have the ability to design the ideal plan which meets all their healthcare needs.

These plans help our members maintain wellness and health while protecting them from financial struggle in the event of medical emergencies. Our members have the peace of mind knowing that a team is ready to support and guide them in matters of health and well-being. World Plans offer 4 levels of Essential Benefits and the flexibility of adding optional benefits within the same plan. There are two available Optional Benefits: International Medical Evacuation and Repatriation. Deductible options give members control over their premium.

Geographical Zones and Coverage

World 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 World plans.

Zone 1

USA, Austria, Bahamas, Brazil, Canada, Denmark, Germany, Hong Kong, Ireland, Luxembourg, Mexico, Monaco, Netherlands, Norway, Panama, Singapore, Switzerland and United Kingdom

Zone 2

Belgium, Bulgaria, Costa Rica, Croatia, Cyprus, Czech Republic, Estonia, Finland, Greece, Hungary, Iceland, Israel, Italy, Lithuania, Liechtenstein, Malta, Portugal, Slovakia, Slovenia, Spain, South Africa, Sweden, Taiwan, Thailand and Turkey

The World plans offer worldwide travel coverage as follows:

- **Zone 1:** up to 90 days of worldwide coverage
- **Zone 2:** up to 90 days of coverage within the zone 2 countries and up to 30 days of coverage for medical emergency services in any other country

Coverage Highlights

Annual Limit:
\$500,000-\$1,000,000 USD

The World Plans are affordable with four different plan designs and multiple options available. Each Plan includes Essential benefits at different deductible and cost share amounts.

- Plan Coverage limits range from: \$500,000-\$1,000,000 USD
- Unmarried dependent children are covered up to age 26 if in full-time education.
- Provider Access within the U.S.: as an exclusive member, you are covered at 100% of Usual, Reasonable and Customary charges when receiving care by 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.

Benefits Highlights by Plan

| World Bronze | World Silver |
|-------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| Annual Limit: \$500,000 Eligibility Ages: 18-59 | Annual Limit: \$1,000,000 Eligibility Ages: 18-59 |
|  Essential Benefits (Inpatient care) |  Essential Benefits (Inpatient care) |
|  Maternity care |  Maternity care |
|  Outpatient care |  Outpatient care |
|  Telemedicine* |  Telemedicine* |
|  Pre-existing conditions (Care Management)* |  Pre-existing conditions (Care Management)* |
|  Wellness and Preventive Benefits |  Wellness and Preventive Benefits |
|  International Medical Evacuation & Repatriation |  International Medical Evacuation & Repatriation |
|  Dental and Vision Benefits |  Dental and Vision Benefits |

 Covered

 Optional

 Not covered

* Care Management of certain pre-existing conditions and Telemedicine when Outpatient Care benefits are purchased.

World Plans Summary of Benefits

All benefits are subject to Usual, Reasonable and Customary Charges. 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.
- All benefits are subject to Usual, Reasonable and Customary charges based on the geographic location where services are rendered.
- 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.
- When Premium Care Physicians and/or In-Network Facilities with UnitedHealthcare Global are not available within a 50-mile radius of your local residence, claims will be reimbursed at the applicable Premium Care Physician and/or In-Network Facility rates.

Deductible and Coinsurance Options

| Plan Selection | Deductible? | Coinurance? | Out-of-Pocket Maximum? |
|-----------------------------|--------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|
| World Bronze & World Silver | 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. |
| | \$1,000 | 10% | \$3,000 |
| | \$1,500 | 20% | \$3,000 |
| | \$2,000 | 30% | \$3,000 |

| World Plans Essential Benefits | World Bronze | World Silver | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------|
| Annual Limit | \$500,000 | | \$1,000,000 | |
| Eligibility ages | 18-59 | | 18-59 | |
| All Essential Benefits are subject to Deductible and Coinsurance amounts even if not stated in the individual benefit. | | | | |
| | Worldwide and USA In-Network | USA Out-of-Network | Worldwide and USA In-Network | USA Out-of-Network |
| Deductible and Coinsurance Options <ul style="list-style-type: none"> In-Network and Out-of-Network Deductibles accrue separately Deductible applies to all Services except for Wellness and Preventive Services and an Injury due to an Accident | individual \$1,000 - 10% \$1,500 - 20% \$2,000 - 30% | individual \$1,000 - 50% \$1,500 - 50% \$2,000 - 50% | individual \$1,000 - 10% \$1,500 - 20% \$2,000 - 30% | individual \$1,000 - 50% \$1,500 - 50% \$2,000 - 50% |
| Out-of-pocket maximum <i>applicable to all benefits excluding optional benefits</i> | \$3,000 individual \$6,000 family | \$6,000 individual \$12,000 family | \$3,000 individual \$6,000 family | \$6,000 individual \$12,000 family |
| Pre-Existing Condition <i>(whether disclosed or not disclosed)</i> | not covered | | not covered | |
| Hospital Charges* (paid in full after applicable Deductible and Coinsurance amounts) | semi-private maximum daily rate | not covered | semi-private maximum daily rate | |
| <ul style="list-style-type: none"> Pre-admission testing (<i>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</i>) Room & board, inpatient general nursing care and special diets Intensive care unit/telemetry/surgical intensive care/medical intensive care/trauma/pediatric intensive care* (<i>limited to 120 days per Policy Year</i>) Use of the operating room and recovery room All medicines administered while you are an Inpatient Inpatient routine x-ray and lab tests Blood transfusions, blood plasma, blood plasma expanders, and all related testing, components, equipment and Services Medical and Surgical Supplies and Dressings Inpatient respiratory therapy rendered by a Physician or registered respiratory therapist Physician, Osteopath and Specialist services (<i>limited to one specialty per day</i>) | | | | |
| In-hospital advanced diagnostic services <i>(e.g., MRI, CT scans, nuclear imaging)</i> | maximum benefit \$5,000 | not covered | maximum benefit \$10,000 | |
| Surgical appliances and prosthesis Covered for prosthetic, surgical, orthopedic and cardiac procedures which are an integral part of the surgical procedure when medically necessary. Please refer to your policy for a list of devices, appliances or prostheses that may be excluded | maximum benefit \$2,500 | not covered | maximum benefit \$2,500 | |
| Parent accommodation for an Insured Person under 18 years old who is hospitalized | not covered | | maximum benefit \$500 | |
| Emergency dental treatment Due to Accident or Injury requiring Hospitalization and resulting in damage to natural sound teeth and treated within 24 hours of the emergency event | not covered | | maximum benefit \$500 | |
| 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 | use of an emergency room for a non-emergency service is not covered | | use of an emergency room for a non-emergency service is not covered | |
| Organ transplant* <ul style="list-style-type: none"> Maximum benefit 2 per lifetime Includes heart, heart and lung, kidney, kidney and pancreas, liver, cornea, bone and skin grafts, small intestines and allogenic and autologous, bone marrow (<i>refer to your policy for coverage of approved diagnosis</i>), blood and stem cell transplants | not covered | | maximum benefit \$25,000 | not covered |

Benefits are subject to the limitations and exclusions contained in the policy and are payable at Usual, Reasonable and Customary Charges.
All Treatment must be Medically Necessary.
Services with an asterisk must be Pre-Authorized by Plan Administrator.

| World Plans Essential Benefits | World Bronze | | World Silver | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-----------------------|------------------------------------------------------------------|-----------------------------|
| | Worldwide and USA In-Network | USA Out-of-Network | Worldwide and USA In-Network | USA Out-of-Network |
| Inpatient rehabilitation* Includes physical therapy (due to an Accident), pulmonary rehab and cardiac rehab (when medically supervised after heart attack, heart failure or invasive heart procedures) which is initiated post-surgery | maximum benefit \$2,500 | not covered | maximum benefit \$5,000 | |
| Inpatient mental and behavioral health* Treatment must be provided in an accredited Psychiatric unit of a Hospital and must be under the direct control of a Psychiatric Physician | maximum benefit \$2,500 | not covered | maximum benefit \$5,000 | |
| 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. This benefit has a specific limit for Hodgkin's Lymphoma, Pancreatic and Liver cancers | maximum benefit \$10,000 | not covered | maximum benefit \$10,000 | |
| Inpatient renal failure dialysis* For acute renal failure not the result or complication of a chronic condition | maximum benefit \$15,000 | not covered | maximum benefit \$25,000 | maximum benefit \$12,500 |
| Inpatient reconstructive surgery* Due to illness or injury e.g., breast reconstruction or other bodily reconstruction due to trauma, infection, tumors or disease | not covered | | maximum benefit \$10,000 | |
| Emergency ground ambulance Limited to a one way trip when responding to a medical emergency | paid in full after applicable Deductible and Coinsurance amounts | | paid in full after applicable Deductible and Coinsurance amounts | |
| 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 | not covered | | maximum benefit \$2,500 | |
| Hospice or palliative care* Accommodation, nursing care and support for the treatment of end of life stages | not covered | | maximum benefit \$2,500 | |
| Maternity Care and Birth Benefits* (subject to 12 month waiting period and notification within 30 days of pregnancy confirmation) | | | | |
| Maternity care Includes pre-natal care, delivery, hospital stay, and post-natal care by obstetrician | not covered | | not covered | |
| Well baby Includes pediatrician and/or neonatologist, and hospital stay after birth (well baby only and is discharged with mother). Baby must be timely added to the policy | not covered | | not covered | |
| Breast pumps Breast pumps must be obtained through an In-Network Durable Medical Equipment Provider who must be able to verify that you are either scheduled for delivery or have delivered within 9 months | not covered | | not covered | |
| Complications of pregnancy (mother only) Miscarriage, preeclampsia, ectopic pregnancy and c-section | not covered | | not covered | |
| Non-healthy newborn infant care When a sick newborn infant is born in the hospital under a covered maternity and baby is timely added to the policy | not covered | | not covered | |
| Congenital conditions Congenital conditions must manifest themselves before 18th birthday for a newborn under a covered maternity and baby must be timely added to the policy | not covered | | not covered | |

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All Treatment must be Medically Necessary.
Services with an asterisk must be Pre-Authorized by Plan Administrator.

| World Plans Outpatient Care | World Bronze | World Silver | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|-----------------------|---------------------------------|-----------------------|
| <i>These services must be performed in a Premium Care Physician's office or in an In-Network, free standing diagnostic center. This will maximize your benefit and reduce your costs. Deductible and coinsurance apply to all benefits unless otherwise stated in the individual benefit.</i> | | | | |
| | Worldwide and USA In-Network | USA Out-of-Network | Worldwide and USA In-Network | USA Out-of-Network |
| Care Management Services for Selected Pre-Existing Conditions Under the list of selected pre-existing conditions, the member has access to the following Care Management services: (i) may schedule up to 6 visits a year with a Primary Care Physician; (ii) has availability to 6 Specialist visits per policy year for the Care Management of medical conditions covered under the plan; (iii) may have access to the use of certain outpatient generic medications; and (iv) basic diagnostics. All other services related to these conditions and any other pre-existing medical conditions are excluded from coverage | | not covered | | not covered |
| Outpatient mental and behavioral health* Treatment must be provided in a physician's office under the direct control of a psychiatric physician | | not covered | | not covered |
| 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. This benefit has a specific limit for Hodgkin's Lymphoma, Pancreatic and Liver cancers | | not covered | | not covered |
| Outpatient renal failure dialysis* For acute renal failure not the result or complication of a chronic condition | | not covered | | not covered |
| Outpatient reconstructive surgery* Due to illness or injury, bodily reconstruction due to trauma, infection, tumors or disease | | not covered | | not covered |
| Outpatient ambulatory surgical facility & surgical care* (free-standing only) <ul style="list-style-type: none"> Some complex medical procedures may require an assistant surgeon or co-surgeon performing services (maximum coverage amount is 20% of the approved fees for the main surgeon). This applies only to procedures for which an assistant surgeon or co-surgeon is indicated by evidence based medicine Services provided by an anesthesiologist during a covered surgical procedure is a covered service by an in-network provider (maximum coverage amount is 30% of the approved fees for the main surgeon) | | not covered | | not covered |
| Surgical appliances and prosthesis Covered for prosthetic, surgical, orthopedic and cardiac procedures which are an integral part of the surgical procedure when medically necessary. Please refer to your policy for a list of devices, appliances or prostheses that may be excluded | | not covered | | not covered |
| Urgent care clinic / facility Services for non-critical but urgent care needs such as: <ul style="list-style-type: none"> Animal bites Cuts, scrapes and minor wounds Minor burns Minor eye irritations or infections Rash, poison ivy, or allergies Sprains, strains, dislocations and minor fractures | | not covered | | not covered |
| Basic diagnostic services At a physician's office or in a free-standing non-hospital facility, e.g., laboratory tests, x-rays, ultrasounds, EKG, echocardiography (this list is not exclusive) | | not covered | | not covered |
| Advanced diagnostic and imaging services* In a free-standing non-hospital facility, e.g., MRI, CT scans, PET scans, nuclear imaging, diagnostic colonoscopy/endoscopy (this list is not exclusive) | | not covered | | not covered |

Benefits are subject to the limitations and exclusions contained in the policy and are payable at Usual, Reasonable and Customary Charges.
All Treatment must be Medically Necessary.
Services with an asterisk must be Pre-Authorized by Plan Administrator.

| World Plans Outpatient Care | World Bronze | | World Silver | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|-----------------------|---------------------------------|-----------------------|
| | Worldwide and USA In-Network | USA Out-of-Network | Worldwide and USA In-Network | USA Out-of-Network |
| Outpatient therapeutic services* <i>All Services require long term and short term goals and a written treatment plan. Maintenance therapy is not covered</i> <ul style="list-style-type: none"> Physical therapy (due to Accident) Speech therapy (due to Accident) Occupational therapy (due to Accident) Pulmonary and cardiac therapy (when medically supervised after heart attack, heart failure or invasive heart procedures) which is initiated post-surgery | | not covered | | not covered |
| Durable medical equipment* <i>Helps to complete your daily activities e.g., walker, wheelchair, oxygen device or other equipment that can withstand repeated use (must be prescribed by a physician)</i> | | not covered | | not covered |
| Physician Services | | | | |
| <i>These services must be performed in a Premium Care Physician's office or in an In-Network, free standing diagnostic center. This will maximize your benefit and reduce your costs.</i> | | | | |
| Teladoc® consultations <i>For illnesses including cold & flu symptoms, allergies, pink eye, respiratory infection, sinus problems and skin problems</i> | | not covered | | not covered |
| Primary care visit <i>(for conditions not related to Care Management Services)</i> <i>Includes physicians, osteopaths, general or family practitioner and gynecologist or other specialist (when designated as the primary care physician)</i> | | not covered | | not covered |
| Specialist visit <i>(for conditions not related to Care Management Services)</i> <i>When your medical condition or diagnosis requires that you are treated by a physician with specific training for your condition or diagnosis. This benefit excludes mental and behavioral health specialist visits</i> | | not covered | | not covered |
| Alternative medicine <i>(combined maximum of 15 visits per policy year)</i> <i>Acupuncture, chiropractic, homeopathy, dietetics</i> | | not covered | | not covered |
| Podiatry <i>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</i> | | not covered | | not covered |
| Outpatient Prescription Drug and Supplies | | | | |
| Benefit is not subject to Deductible or Out-of-Pocket Maximum | Worldwide and USA In-Network | USA Out-of-Network | Worldwide and USA In-Network | USA Out-of-Network |
| <ul style="list-style-type: none"> Generic dispensed when available Brand will only be dispensed if generic is not available and it is medically necessary If a Brand medication is prescribed for a Generic equivalent which is not available in the geographic area, the maximum benefit of \$250 will apply to the Brand medication | | not covered | | not covered |

Benefits are subject to the limitations and exclusions contained in the policy and are payable at Usual, Reasonable and Customary Charges. All Treatment must be Medically Necessary. Services with an asterisk must be Pre-Authorized by Plan Administrator.

| World Plans Wellness and Preventive Benefits | World Bronze | World Silver | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|-----------------------|---------------------------------|-----------------------|
| <i>These services must be performed in a Premium Care Physician's office or in an In-Network, free standing diagnostic center. This will maximize your benefit and reduce your costs. Deductible and Coinsurance do not apply.</i> | | | | |
| Adult Wellness Visit and Preventive Benefits | Worldwide and USA In-Network | USA Out-of-Network | Worldwide and USA In-Network | USA Out-of-Network |
| Wellness Visit <ul style="list-style-type: none"> Your physician will measure your height, weight, take your blood pressure and take other routine measurements; review your medical and family history; assess your risk factors for preventable diseases; check vital signs; perform head and neck exam, lung exam, abdominal exam and look for signs of cognitive impairment; test your reflexes; review your health risk assessment questionnaire; update your list of providers and prescriptions; and set up a screening schedule for appropriate preventive services Blood work and urinalysis, cholesterol screening for adults of certain ages or at higher risk, colorectal cancer screening for adults 50 to 75 (fecal occult blood test only), depression screening assessment questionnaire, and diabetes (Type 2) screening for adults 40 to 70 years who are overweight or obese | | not covered | | not covered |
| Annual Preventive screenings (1 per year) <ul style="list-style-type: none"> - Papanicolaou (PAP) screening - Mammogram (eligible age: 40 years and over) - PSA lab screening test (eligible age: 50 years and over) | | not covered | | not covered |
| Other Preventive screenings (one year waiting period) <ul style="list-style-type: none"> - Bone density test (eligible age: 45 and over, limited to 1 every 5 years) - Colonoscopy (eligible age: 45 years and over, limited to 1 every 10 years) | | not covered | | not covered |
| Immunizations and vaccinations Hepatitis A, Hepatitis B, Human Papillomavirus (HPV), Influenza (flu shot), Tetanus, COVID-19. In the USA, vaccinations and immunizations must be provided by an EHIM In-Network pharmacy only | | not covered | | not covered |
| Well-child Benefits Periodic age specific physical examinations and developmental assessments; office visit; diagnostic tests; vaccination and immunization necessary for prevention; health history; hearing examinations; age related (Measles, Meningococcal, Mumps, Pertussis, Pneumococcal, Rubella, Tetanus, Varicella (Chickenpox), COVID-19); and track growth and development in accordance with pediatric guidelines | | not covered | | not covered |

Optional Benefits

| World Plans International Medical Evacuation & Repatriation* | World Bronze | World Silver |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|--------------------------------------------------------------------------------|
| <i>Deductible and Coinsurance apply as chosen under Essential Benefits</i> | | |
| Emergency medical evacuation Transportation to the nearest facility if the treatment needed is not available locally | | |
| Medical repatriation Members can return to their country of origin following an approved emergency medical evacuation as long as they are physically and medically stable | not covered | Paid in full up to \$30,000 combined limit per insured person, per policy year |
| Repatriation of mortal remains Transportation cost and cost for burial or cremation | not covered | Paid in full up to \$25,000 combined limit per insured person |
| Companion coverage travel costs and living allowance | not covered | Transportation (economy-class flight) + \$1,000 for living allowance |

Benefits are subject to the limitations and exclusions contained in the policy and are payable at Usual, Reasonable and Customary Charges.
All Treatment must be Medically Necessary.
Services with an asterisk must be Pre-Authorized by Plan Administrator.



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