Expat Plans
In-Network Benefits Plan Comparison

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WellAway

January 1, 2026

EXPAT PLANS
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	Gold 1000	Gold 2000	Gold 5000	Diamond 1000	Diamond 2000	Diamond 5000	Plus
Member Responsibility							
Limit & Cost Sharing							
Deductible	$1,000 – Individual $2,000 – Family	$2,000 – Individual $4,000 – Family	$5,000 – Individual $10,000 – Family	$1,000 – Individual $2,000 – Family	$2,000 – Individual $4,000 – Family	$5,000 – Individual $10,000 – Family	$0 – Individual $0 – Family
In-Network Coinsurance (You Pay)	20%	20%	20%	No Coinsurance	No Coinsurance	No Coinsurance	No Coinsurance
Out-of-Network Fee Schedule	N/A	N/A	N/A	N/A	N/A	N/A	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	$6,000 – Individual $12,000 – Family	$7,000 – Individual $14,000 – Family	$1,000 – Individual $2,000 – Family	$2,000 – Individual $4,000 – Family	$5,000 – Individual $10,000 – Family	N/A
What Your Plan Pays							
Maximum Annual Coverage	$1,000,000	$1,000,000	$1,000,000	$3,000,000	$3,000,000	$3,000,000	$3,000,000
Preventive Services							
DEDUCTIBLE DOES NOT APPLY TO THIS BENEFIT	No Coinsurance	No Coinsurance	No Coinsurance	No Coinsurance	No Coinsurance	No Coinsurance	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.							

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Services That Require Hospitalization							
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%	20%	20%	No Coinsurance	No Coinsurance	No Coinsurance	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 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 20% Coinsurance of the Average Semi-Private room rate, subject to the $2,000 maximum daily benefit	No Coinsurance paid in full at average private room rate per day	No Coinsurance paid in full at average private room rate per day	No Coinsurance paid in full at average private room rate per day	No Coinsurance paid in full at average private room rate per day
Intensive Care Unit/Telemetry/Surgical Intensive Care/Medical Intensive Care/Trauma/Pediatric Intensive Care*	20% (Maximum 180 days per Policy Year)	20% (Maximum 180 days per Policy Year)	20% (Maximum 180 days per Policy Year)	No Coinsurance (Maximum 180 days per Policy Year)	No Coinsurance (Maximum 180 days per Policy Year)	No Coinsurance (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)	20% Maximum 10 days per Policy Year	20% Maximum 10 days per Policy Year	20% Maximum 10 days per Policy Year	No Coinsurance Maximum 30 day limit per Policy Year	No Coinsurance Maximum 30 day limit per Policy Year	No Coinsurance Maximum 30 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.	20%	20%	20%	No Coinsurance	No Coinsurance	No Coinsurance	No Coinsurance
Inpatient Physician and Specialist Services	20% (Maximum 1 specialty per day)	20% (Maximum 1 specialty per day)	20% (Maximum 1 specialty per day)	No Coinsurance (Maximum 1 specialty per day)	No Coinsurance (Maximum 1 specialty per day)	No Coinsurance (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	20% Maximum Benefit $1,000 per Service	20% Maximum Benefit $1,000 per Service	No Coinsurance Maximum Benefit $3,000 per Service	No Coinsurance Maximum Benefit $3,000 per Service	No Coinsurance Maximum Benefit $3,000 per Service	No Coinsurance Maximum Benefit $3,000 per Service
Inpatient Routine X-rays and Lab Tests (tests commonly performed while Inpatient)	20%	20%	20%	No Coinsurance	No Coinsurance	No Coinsurance	No Coinsurance

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Services That Require Hospitalization							
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	20% Maximum Benefit $25,000 per Policy Year	20% Maximum Benefit $25,000 per Policy Year	No Coinsurance 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	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.	20% Maximum Benefit $150,000	20% Maximum Benefit $150,000	20% Maximum Benefit $150,000	No Coinsurance Maximum Benefit $350,000	No Coinsurance Maximum Benefit $350,000	No Coinsurance Maximum Benefit $350,000	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.	20% Maximum Benefit $50,000	20% Maximum Benefit $50,000	20% Maximum Benefit $50,000	No Coinsurance Maximum Benefit $75,000	No Coinsurance Maximum Benefit $75,000	No Coinsurance Maximum Benefit $75,000	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.	20% Maximum 30 days per Policy Year	20% Maximum 30 days per Policy Year	20% Maximum 30 days per Policy Year	No Coinsurance Maximum 36 day limit per Policy Year	No Coinsurance Maximum 36 day limit per Policy Year	No Coinsurance Maximum 36 day limit per Policy Year	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.	20%	20%	20%	No Coinsurance	No Coinsurance	No Coinsurance	No Coinsurance

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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	20% Maximum Benefit $10,000	20% Maximum Benefit $10,000	No Coinsurance	No Coinsurance	No Coinsurance	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.	20% Maximum Benefit $50,000 Lifetime	20% Maximum Benefit $50,000 Lifetime	20% Maximum Benefit $50,000 Lifetime	No Coinsurance Maximum Benefit $60,000 Lifetime	No Coinsurance Maximum Benefit $60,000 Lifetime	No Coinsurance Maximum Benefit $60,000 Lifetime	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)	20%	20%	20%	No Coinsurance	No Coinsurance	No Coinsurance	No Coinsurance
Outpatient Care							
Urgent Care Clinic / Facility	20%	20%	20%	No Coinsurance	No Coinsurance	No Coinsurance	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%	20%	20%	No Coinsurance	No Coinsurance	No Coinsurance	No Coinsurance

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Outpatient Care							
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%	20%	20%	No Coinsurance	No Coinsurance	No Coinsurance	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	20% Maximum Benefit $3,000 per Policy Year	20% Maximum Benefit $3,000 per Policy Year	No Coinsurance Maximum Benefit $4,000 per Policy Year	No Coinsurance Maximum Benefit $4,000 per Policy Year	No Coinsurance Maximum Benefit $4,000 per Policy Year	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)	20% Maximum allowance $100 per session, Maximum 20 sessions per Policy Year	20% Maximum allowance $100 per session, Maximum 20 sessions per Policy Year	20% Maximum allowance $100 per session, Maximum 20 sessions per Policy Year	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	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
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	20% Maximum Benefit $25,000 per Policy Year	20% Maximum Benefit $25,000 per Policy Year	No Coinsurance Maximum Benefit $100,000 limit per Policy Year	No Coinsurance Maximum Benefit $100,000 limit per Policy Year	No Coinsurance Maximum Benefit $100,000 limit per Policy Year	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.	20% Maximum Benefit $150,000 per Policy Year	20% Maximum Benefit $150,000 per Policy Year	20% Maximum Benefit $150,000 per Policy Year	No Coinsurance Maximum Benefit $350,000 per Policy Year	No Coinsurance Maximum Benefit $350,000 per Policy Year	No Coinsurance Maximum Benefit $350,000 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.	20% Maximum Benefit $50,000 per Policy Year	20% Maximum Benefit $50,000 per Policy Year	20% Maximum Benefit $50,000 per Policy Year	No Coinsurance Maximum Benefit $75,000 per Policy Year	No Coinsurance Maximum Benefit $75,000 per Policy Year	No Coinsurance Maximum Benefit $75,000 per Policy Year	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)	20% 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	20% Maximum Benefit $250 per tooth up to $1,000 per Policy Year	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	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

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Outpatient Care							
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	20% 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	No Coinsurance Maximum 90 days per Policy Year	No Coinsurance Maximum 90 days per Policy Year	No Coinsurance Maximum 90 days per Policy Year	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)	20% 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	20% Maximum Benefit $15,000 or 60 days per Policy Year, whichever occurs first	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	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
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	20% Maximum Benefit $1,500 per Policy Year	20% Maximum Benefit $1,500 per Policy Year	No Coinsurance Maximum Benefit $3,000 per Policy Year	No Coinsurance Maximum Benefit $3,000 per Policy Year	No Coinsurance Maximum Benefit $3,000 per Policy Year	No Coinsurance Maximum Benefit $3,000 per Policy Year
Physician Services							
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	No Co-payment Maximum 8 consults per Policy Year	No Co-payment Maximum 8 consults per Policy Year	No Co-payment Maximum 8 consults per Policy Year	No Co-payment Maximum 8 consults per Policy Year	No Co-payment Maximum 8 consults per Policy Year	No Co-payment Maximum 8 consults per Policy Year
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	20% Maximum allowance $150 per visit	20% Maximum allowance $150 per visit	No Coinsurance Maximum allowance $250 per visit	No Coinsurance Maximum allowance $250 per visit	No Coinsurance Maximum allowance $250 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.	20% Maximum allowance $150 per visit	20% Maximum allowance $150 per visit	20% Maximum allowance $150 per visit	No Coinsurance Maximum allowance $250 per visit	No Coinsurance Maximum allowance $250 per visit	No Coinsurance Maximum allowance $250 per visit	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.	20% Maximum allowance $300 per visit	20% Maximum allowance $300 per visit	20% Maximum allowance $300 per visit	No Coinsurance Maximum allowance $400 per visit	No Coinsurance Maximum allowance $400 per visit	No Coinsurance Maximum allowance $400 per visit	No Coinsurance Maximum allowance $400 per visit

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Physician Services							
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	20% Maximum 10 visits per Policy Year	20% Maximum 10 visits per Policy Year	No Coinsurance Maximum 25 visits per Policy Year	No Coinsurance Maximum 25 visits per Policy Year	No Coinsurance Maximum 25 visits per Policy Year	No Coinsurance Maximum 25 visits per Policy Year
Alternative Medicine (acupuncture, chiropractic, homeopathy only)	20% 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	20% Maximum allowance $100 per session Combined Maximum 5 visits per Policy Year	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	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
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	20% Maximum allowance $100 per session Maximum 5 visits per Policy Year	20% Maximum allowance $100 per session Maximum 5 visits per Policy Year	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	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
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%	20%	20%	No Coinsurance	No Coinsurance	No Coinsurance	No Coinsurance
Outpatient Prescription Drugs and Supplies							
• Generic Medications only • Not subject to Deductible or Out-of-Pocket Maximum	20%	20%	20%	No Coinsurance	No Coinsurance	No Coinsurance	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 $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 $15,000	No Coinsurance Maximum Benefit $15,000	No Coinsurance Maximum Benefit $15,000	No Coinsurance Maximum Benefit $25,000	No Coinsurance Maximum Benefit $25,000	No Coinsurance Maximum Benefit $25,000	No Coinsurance Maximum Benefit $25,000

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United Healthcare Global

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payerfusion

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