

New American 1500 Brochure

WellAway

wellaway.com

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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



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

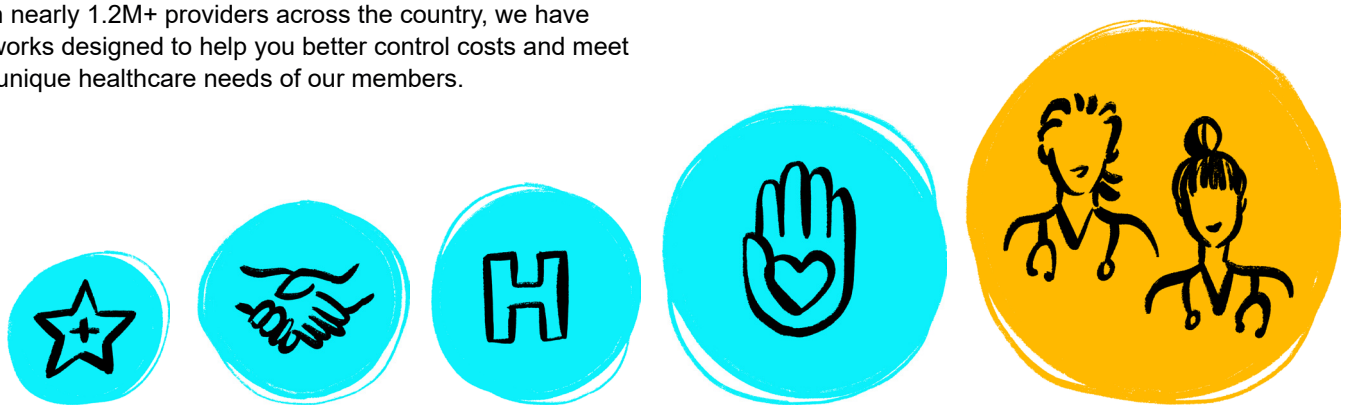
Using Telehealth to speak with your doctors can treat many medical conditions, including but not limited to:

- 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

New American 1500

ACA-compliant coverage specifically for US-bound expatriates with international coverage for up to 179 days.

The New American is an all-encompassing health & lifestyle product designed to meet the needs of US-bound expatriates. Our comprehensive health product has USA-compliant coverage and support tools that allow members to rest assured that they are abiding by the United States' health insurance mandates. All plans meet the minimum essential coverage required by the Affordable Care Act, including unlimited annual maximums.

Our members are comforted knowing that home is always with them in all matters relating to their health and well-being. The New American provides health benefits, wellness tools and access to medical services designed for the expatriate lifestyle. Feel empowered with WellAway's assistance in finding the right medical provider in your area from our expansive network of healthcare professionals or allowing you to request second medical opinions for complex diagnoses. We are committed to developing a complete support system for foreign nationals.

Coverage Highlights

Annual Limit:
UNLIMITED

For US-bound expatriates seeking health and wellness solutions to maintain their expat lifestyles.

- Fully accredited plan for coverage in the USA, meeting all Minimum Essential Coverage requirements as mandated by the Affordable Care Act.
- Deductible: $1,500 individual, $3,000 family
  Annual Out-of-Pocket Maximum: $4,000 individual, $8,000 family
- Provider Access within the U.S.: as an exclusive member, you are covered at 100% of Usual, Customary and Reasonable charges when receiving care by Premium Care Physicians and at In-Network Facilities with UnitedHealthcare Global.
- Worldwide coverage available for up to 179 days per benefit period. Provider Access outside of the U.S.: An open-access network allows our members the flexibility to see a variety of doctors. Contact us and we will help you find the best doctor at the fairest price.
- Our plans are flexible to meet your needs. Dental & vision coverage are available.
- Unmarried dependent children are covered up to age 26.
- 24/7 multi-lingual ConciergeCare service included at no extra cost.

New American 1500 Summary of Benefits

All benefits are subject to Usual, Customary and Reasonable Charges. Our ConciergeCare team will help you locate the most appropriate Provider for you and assist you in scheduling an appointment.

Important Points You Should Know

- The UnitedHealth Premium® 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 amount as specified under your Summary of Benefits.
- Benefits are shown per person, per benefit period.

USA Benefits

- Maximum amounts apply to certain services.
- All benefits are subject to Usual, Customary and Reasonable 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.
- You have access to special claims and administrative services within the USA.
- We provide you with access to more than 1.2M+ providers with UnitedHealthcare Global.

Worldwide Benefits (Available for up to 179 days per benefit period)

- Maximum amounts apply to certain services.
- All benefits are subject to Usual, Customary and Reasonable Fees 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.
- Guarantee of Payment available upon hospital discretion to accept payment from WellAway.

Cost Share Features	In-Network (INN)	Out-of-Network (ONN)	Worldwide
Annual limit	Unlimited	Unlimited	$1,000,000
Policy Year Deductible- Embedded			
Individual Deductible (The amount you pay)	$1,500 individual	$3,000 individual	No Deductible
Family Deductible (The amount your family pays)	$3,000 family	$6,000 family	No Deductible
Coinsurance			
(This Summary of Benefits states the percentage of the Allowed Amount **you pay** for Covered Services)	10%	50%	10%
Out-of-pocket maximum			
Individual Out-of-Pocket maximum	$4,000 individual	$8,000 individual	Unlimited
Family Out-of-Pocket maximum	$8,000 family	$16,000 family	Unlimited

Medical Health Benefits

Payment for In-Network Covered Services is based on our **Allowed Amount** and may be less than the amount the Provider bills for such Services. Certain benefits indicated in this Summary of Benefits table require that you utilize an In-Network Provider.

Your Cost Share for Covered Services will vary based on In-Network Services or Out-of-Network Services. In-Network Premium Care or Select Providers will provide you with the least Out-of-Pocket costs. Non-Premium Care or Select Providers, while In-Network, may be subject to excess or differentials in addition to your Cost Share amounts. You should always verify a Provider's participation status before you receive Health Care 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.

Any Copayments listed in this Summary of Benefits table below apply per visit.

Wellness Care

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

Adult Wellness Services (at all locations) Periodic routine health exams include: • routine gynecological exams including pap smears • immunizations • prostate specific antigen (age specific supported by the U.S. Preventive Services Task Force) • routine mammograms (age specific supported by the Health Resources and Services Administration) • measure your height, weight, blood pressure and take other routine measurements • review your medical and family history assess your risk factors and treatment options • review your health risk assessment questionnaire • update your list of providers and prescriptions • look for signs of cognitive impairment • set up a screening schedule for appropriate preventive services	No Charge	Not covered	10% Coinsurance

Wellness Care	In-Network (INN)	Out-of-Network (ONN)	Worldwide
These Services must be performed in an In-Network Premium Care Physician's/Select Provider's office or free-standing Facility otherwise they will not be covered.			
Child Wellness Services (at all locations) Periodic age specific physical examinations and developmental assessment in accordance with pediatric guidelines • office visit • health history • hearing examinations • age related diagnostic tests • vaccination and immunization necessary for prevention	No Charge	Not Covered	10% Coinsurance

Services that Require Hospitalization

Hospitalization* (Facility)	Deductible then you pay 10% Coinsurance	Deductible then you pay 50% Coinsurance	10% Coinsurance
Emergency room (Facility) (Emergency means when your health is in jeopardy, your symptoms are severe potentially causing loss of life, limb or death (medically necessary)) If you use the Hospital Emergency for a non-emergency service, the Services will not be covered.	Deductible then you pay 10% Coinsurance	Deductible then you pay 50% Coinsurance	10% Coinsurance
Physician Services (Primary Care Physicians and Specialist Physicians)	Deductible then you pay 10% Coinsurance	Deductible then you pay 50% Coinsurance	10% Coinsurance
Rehabilitative services* (treatment of CVA, head injury, spinal cord injury, or as required as a result of post-operative brain surgery when certain criteria are met)	Deductible then you pay 10% Coinsurance Limited to 45 days combined with Habilitative Services	Deductible then you pay 50% Coinsurance Limited to 45 days combined with Habilitative Services	10% Coinsurance Limited to 45 days combined with Habilitative Services
Habilitative services* (occupational, physical and speech therapy when certain criteria are met)	Deductible then you pay 10% Coinsurance Limited to 45 days combined with Rehabilitative Services	Deductible then you pay 50% Coinsurance Limited to 45 days combined with Rehabilitative Services	10% Coinsurance Limited to 45 days combined with Rehabilitative Services
Behavioral health services* (mental health such as psychotherapy and counseling & substance use disorder services)	Deductible then you pay 10% Coinsurance	Deductible then you pay 50% Coinsurance	10% Coinsurance
Surgical procedures and surgeon fees * • refers to the fees charged by the main surgeon that performed the surgical procedure. • Some complex medical procedures may require an assistant surgeon or co-surgeon performing services. • Services provided by an anesthesiologist during a covered surgical procedure.	Deductible then you pay 10% Coinsurance	Deductible then you pay 50% Coinsurance	10% Coinsurance
Oncology treatment* (includes chemotherapy, radiation or pharmaceutical treatments which have approved efficacy and market distribution)	Deductible then you pay 10% Coinsurance	Deductible then you pay 50% Coinsurance	10% Coinsurance

** Prior Coverage Authorization required*

Services that Require Hospitalization	In-Network (INN)	Out-of-Network (ONN)	Worldwide
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 the ability in restoring normal life functions)	Deductible then you pay 10% Coinsurance	Deductible then you pay 50% Coinsurance	10% Coinsurance
Organ transplant* (includes heart, lung, heart and lung, kidney, pancreas, kidney and pancreas, liver, cornea, allogenic and autologous bone marrow and peripheral stem cell transplants)	Deductible then you pay 10% Coinsurance	Deductible then you pay 50% Coinsurance	10% Coinsurance
Emergency ambulance services (from emergency location to nearest facility, from one hospital to another, or from hospital to your home or skilled nursing facility)	Deductible then you pay 10% Coinsurance		10% Coinsurance

Outpatient Care

When Services are not performed in a Physician's office or in a free-standing non-hospital facility, a Site of Service Differential cost will apply.

Urgent care center	$55 Copayment	$105 Copayment	10% Coinsurance
Outpatient ambulatory surgical facility * (Free-standing non-hospital Facility only)	Deductible then you pay 10% Coinsurance	Deductible then you pay 50% Coinsurance	10% Coinsurance
Outpatient Surgery Physician/Surgical Services • refers to the fees charged by the main surgeon that performed the surgical procedure. • Some complex medical procedures may require an assistant surgeon or co-surgeon performing services. • Services provided by an anesthesiologist during a covered surgical procedure.	Deductible then you pay 10% Coinsurance	Deductible then you pay 50% Coinsurance	10% Coinsurance
Oncology treatment* (includes chemotherapy, radiation or pharmaceutical treatments which have approved efficacy and market distribution)	Deductible then you pay 10% Coinsurance	Deductible then you pay 50% Coinsurance	10% Coinsurance
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 the ability in restoring normal life functions)	Deductible then you pay 10% Coinsurance	Deductible then you pay 50% Coinsurance	10% Coinsurance
Routine X-rays and Laboratory Tests	$95 Copayment	Deductible then you pay 50% Coinsurance	10% Coinsurance
Advanced diagnostic and imaging services* (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$250 Copayment	Deductible then you pay 50% Coinsurance	10% Coinsurance

** Prior Coverage Authorization required*

Outpatient Care

	In-Network (INN)	Out-of-Network (OON)	Worldwide
When Services are not performed in a Physician's office or in a free-standing non-hospital facility, a Site of Service Differential cost will apply.			
Rehabilitative services* (for treatment of CVA, head injury, spinal cord injury, or as required as a result of post-operative brain surgery when certain criteria are met)	$45 Copayment (limited to 20 visits per benefit period)	Deductible then you pay 50% Coinsurance (limited to 20 visits per benefit period)	10% Coinsurance (limited to 20 visits per benefit period)
Habilitative services* (limited to occupational, physical and speech therapy when certain criteria are met)	$45 Copayment (limited to 20 visits per benefit period)	Deductible then your pay 50% Coinsurance (limited to 20 visits per benefit period)	10% Coinsurance (limited to 20 visits per benefit period)
Outpatient physical therapy* (physical therapy for the purpose of aiding in the restoration of normal physical function lost due to a Condition or to attain age appropriate function for activities of daily living - treatment plan must be provided)	$45 Copayment (limited to 40 visits per benefit period)	Deductible then you pay 50% Coinsurance (limited to 40 visits per benefit period)	10% Coinsurance (limited to 40 visits per benefit period)
Outpatient Chiropractic Services (chiropractic services and spinal manipulation *(to correct a slight dislocation of a bone or joint that is demonstrated by x-ray*) when restoring function loss due to a medical condition or to attain age-appropriate function for activities of daily living - treatment plan must be provided)	Deductible then you pay 10% Coinsurance (limited to combined 15 visits per benefit period)	Deductible then you pay 50% Coinsurance (limited to combined 15 visits per benefit period)	10% Coinsurance (limited to combined 15 visits per benefit period)
Behavioral health services* (outpatient facility for mental health & substance use disorder services)	$45 Copayment	Deductible then you pay 50% Coinsurance	10% Coinsurance
Emergency dental services (due to damage to natural sound teeth which is treated within 62 days of the accidental dental injury)	Deductible then you pay 10% Coinsurance	Deductible then you pay 50% Coinsurance	10% Coinsurance
Vision services (for the treatment of aphakia, injury to or diseases of the eyes and glasses or lenses following cataract surgery)	Deductible then you pay 10% Coinsurance	Deductible then you pay 50% Coinsurance	10% Coinsurance

Physician Services

Virtual Visits (for illnesses including cold & flu symptoms, allergies, pink eye, respiratory infection, sinus problems and skin problems)	No Charge	Not covered	Not available
Primary Care (includes general consultation, primary care visit, check- ups, office visits, and gynecologist when designated as your primary care physician)	$25 Copayment	Deductible then you pay 50% Coinsurance	10% Coinsurance
Specialist consultation (consultation or office visit for a specific condition or specialty)	$40 Copayment	Deductible then you pay 50% Coinsurance	10% Coinsurance
Behavioral Health (includes office visit, diagnostic evaluation, psychiatric treatment, individual therapy, and group therapy rendered to you by a physician, psychologist or mental health professional for the treatment of a mental health illness or substance use disorder)	$45 Copayment	Deductible then you pay 50% Coinsurance	10% Coinsurance
Allergy testing & treatment* (includes injections for allergies, may include desensitization therapy and the cost of hypo-sensitization serum)	$40 Copayment Maximum Benefit $1,500	Deductible then you pay 50% Coinsurance Maximum Benefit $1,500	10% Coinsurance Maximum Benefit $1,500

** Prior Coverage Authorization required*

Maternity Care

	In-Network (INN)	Out-of-Network (OON)	Worldwide
Prenatal and postnatal physician consultations	No Charge	Deductible then you pay 50% Coinsurance	10% Coinsurance
Labor and delivery Hospital stay minimum 48 hours for normal delivery and 96 hours for c-section (includes hospital, obstetrician, midwife, anesthesiologist, pediatrician (well baby) for a normal delivery)	Deductible then you pay 10% Coinsurance	Deductible then you pay 50% Coinsurance	10% Coinsurance
Complications of Pregnancy (mother only - miscarriage, pre-eclampsia, ectopic pregnancy and c-section)	Deductible then you pay 10% Coinsurance	Deductible then you pay 50% Coinsurance	10% Coinsurance
Birthing center (includes a team of highly qualified professionals from midwifery, nursing, obstetrics, family medicine and childbirth)	$305 Copayment	Deductible then you pay 50% Coinsurance	10% Coinsurance
Newborn care (a newborn child who is properly enrolled will be covered from the moment of birth for injury or illness, including routine care, and the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities and premature birth)	Deductible then you pay 10% Coinsurance	Not covered	10% Coinsurance
Infertility treatment	Not covered	Not covered	Not covered
Sterilization (surgical sterilizations, tubal ligations and vasectomies only)	Deductible then you pay 10% Coinsurance	Deductible then you pay 50% Coinsurance	10% Coinsurance

Prescription Drugs

	EHIM In-Network Pharmacy	Out-of-Network (OON)	Worldwide
Preventive	No Charge	Not covered	10% Coinsurance
Generic	$15 Copayment	Not covered	10% Coinsurance
Brand	$35 Copayment	Not covered	10% Coinsurance
Non-preferred brands	50% Coinsurance	Not covered	10% Coinsurance
Specialty	50% Coinsurance	Not covered	10% Coinsurance

Other Services

	In-Network (INN)	Out-of-Network (OON)	Worldwide
Skilled nursing facility* (following a hospital stay of no less than three (3) days and care must begin within 14 days following your hospital stay)	Deductible then you pay 10% Coinsurance	Deductible then you pay 50% Coinsurance	10% Coinsurance
Home healthcare* (care must begin within 14 days following your hospital stay, prescribed by a physician and provided under the supervision of a registered nurse)	Deductible then you pay 10% Coinsurance	Deductible then you pay 50% Coinsurance	10% Coinsurance
Hospice* (accommodation, nursing care and support for the treatment of end of life stages which must be approved and certified by a physician)	Deductible then you pay 10% Coinsurance	Not covered	10% Coinsurance
Dialysis* (includes equipment, training and medical supplies at a licensed provider location or dialysis center)	$305 Copayment	Deductible then you pay 50% Coinsurance	10% Coinsurance
Durable medical equipment (helps to complete your daily activity and includes walker, wheelchair, crutches, canes, oxygen equipment, hearing aids or other equipment that can withstand repeated use which must be medically necessary and prescribed by a physician)	Deductible then you pay 10% Coinsurance	Deductible then you pay 50% Coinsurance	10% Coinsurance
Prosthetic & Orthotics Devices (when prescribed by a Physician and designed and fitted by a Prosthetist or Orthotist as applicable)	Deductible then you pay 10% Coinsurance	Deductible then you pay 50% Coinsurance	10% Coinsurance

Evacuation & Repatriation

Medical evacuation*	Paid in full up to $100,000 limit per covered person, per benefit period
Repatriation of mortal remains*	Paid in full up to $25,000 lifetime limit per covered person

** Prior Coverage Authorization required*

Pediatric Dental Services

Pediatric Dental Services which exceed $500 are subject to Prior Coverage Authorization

	In-Network/ Out-of-Network and Worldwide
Preventive Dental Services • Oral Exam - *Once every 6 months in a Benefit Period* • Cleaning and fluoride treatments - *Once every 6 months in a Benefit Period* • Sealants – *Once per unrestored permanent molar every 36 months* • Space maintainers to replace prematurely lost teeth. • X-ray (bitewing – two films) – *Once every six months in a Benefit Period*	Your Plan pays 100% of UCR
Basic Dental Services • Anesthesia – general anesthesia and intravenous sedation is covered only when rendered in connection with a covered surgical procedure. • Endodontics – minor (such as pulpal therapy) • Extractions (removal of teeth-except extractions for orthodontics) • Palliative care (treatment to relieve pain or to keep an Accidental Dental Injury or dental Condition, such as an abscess from getting worse). • Periodontics – minor (such as deep cleaning) • Prosthodontics – minor (such as repair and relining of bridges, crowns and dentures) • Fillings, including silver amalgam, silicate, acrylic, plastic, composite (except gold)	Deductible then you pay 20% Coinsurance of UCR
Major Dental Services • Endodontics – major (such as root canal treatment) • Periodontics – surgical (such as gingivectomy) • Prosthodontics – major (such as crowns and dentures - *limited to once every 60 months).* • Implants and orthodontia Services may be covered, when Medically Necessary, and with prior coverage authorization.	Deductible then you pay 20% Coinsurance of UCR

Pediatric Vision Benefits

Pediatric Vision Services are covered **only** when by rendered by an Optometrist. Pediatric Vision Services rendered by an Ophthalmologist are subject to applicable **Cost Share amounts** in your medical plan. Pediatric Vision Benefits are not covered when rendered by Out-of-Network Providers, except for Emergency Services. Pediatric Vision Benefits end on the last day of the calendar month of the Covered Person's 19th birthday.

Covered Service	**In-Network/ Out-of-Network and Worldwide**
Eye exam - one every 12 months • including dilation (when professionally indicated)	Your Plan pays 100% of UCR
Lenses one pair per member every 12 months (provided there were no benefits paid for contact lenses during the same benefit period).	Your Plan pays 100% of UCR
Frames one every 12 months from the Pediatric Frame Selection* * If you choose a frame that is not in the Pediatric Frame Selection you will be responsible for the difference in cost between the price of the frame selected and those available in the Pediatric Frame Selection. Any such amounts will not apply to any Deductibles or Out-of-Pocket maximums.	Your Plan pays 100% of UCR
Contact Lenses (instead of eye glasses) once every 12 months from the Pediatric Contact Lens Selection** including the evaluation, fitting and follow-up care (provided there were no benefits paid for contact lenses during the same benefit period). ** If you do not select contact lenses from the Pediatric Contact Lens Selection you will be responsible for the difference in cost between the contact lenses selected and those available in the Pediatric Contact Lens Selection. Any such amounts will not apply to any Deductibles or Out-of-Pocket maximums.	Your Plan pays 100% of UCR

WellAway

Keeping You Well, While You're Away.®

United Healthcare Global

payerfusion

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