WORLD INSURANCE

World Health

HSA-Qualified Major Medical Plan

THIS PLAN MEETS THE REQUIREMENTS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010.

F4298 0111

HSA-Qualified Major Medical Plan

Individual Health Insurance Solutions

That You Can Customize to Meet Your Needs

When you choose the *HSA* insurance program from World Insurance Company, you'll get more than solid, reliable health insurance coverage from a financially strong company.

You'll also get the right balance of **cost**, **coverage** and **convenience**.

Affordable Rates - *help keep your expenses down*

- **Program for every budget** - special coverage options help you balance the need for health insurance and stay within your budget
- **Manage your expenses** better with rate protection for up to 2 years

Customized Solutions - *options let you tailor the coverage for a better fit*

- **We developed a flexible health insurance** plan giving you a full range of benefit options so you can customize your coverage
- **Avoid paying for benefits you don't need or never use**

Convenient - *we take care of the paperwork*

- **Streamlined application process** helps you eliminate time-consuming paperwork
- **Automated claim payment system** means you don't waste valuable time filing paperwork if you're sick or hurt

Protection from a Financially Strong Company

World Insurance Company (World) delivers customized health care solutions at an affordable price to individuals and families across the nation.

Establishing trust with our customers and providing them peace of mind is one of the reasons World (Omaha, NE) has been in business for more than 100 years. World helps groups, individuals, families, small businesses and associations with their major medical health insurance needs at an affordable price. World Insurance Company is rated "A-" (Excellent) by industry analyst A.M. Best Company for its financial stability.*

**Our A- (Excellent) rating (April 2010) is the fourth highest of 15 possible ratings given by A.M. Best Company. As an independent non-government company, A.M. Best does not recommend products or services but does provide independent opinions of a company's overall financial strength.*

WORLD® INSURANCE

World HSA Program

What is an HSA?

An HSA – or **Health Savings Account** – is a tax-advantaged account funded by you, allowable when you purchase a special type of insurance known as an **HSA-qualified health plan.**

Money in the account belongs to you, can be used for qualified medical expenses and can be rolled over each year.

World Insurance Company's *HSA* Program is Comprised of Two Money-Saving Components:

1 A specific type of health insurance plan called an HSA-qualified plan

- You get *Comprehensive Major Medical* coverage that protects you financially from major accidents and illnesses
- You get the convenience of a ***Family Deductible*** – not individual deductibles for each family member
- Provides a range of allowable deductibles and maximum out-of-pocket expenses (established by the federal government) which allows you to qualify for an HSA account

2 A special tax-advantaged Health Savings Account (HSA)

- Amount you contribute each year can be deducted from income tax
- Helps pay for everyday qualified health care costs, for example:
  - ✓ *Your deductible*
  - ✓ *Out-of-pocket expenses*
  - ✓ *Eyeglasses and contact lenses*
  - ✓ *Prescriptions and over-the-counter medicines*
  - ✓ *Dental treatments*
  - ✓ *Chiropractic treatments*
  - ✓ *Hearing aids*
  - ✓ *Long Term Care insurance*

  *For additional information about IRS-allowable expenses, please visit the IRS website at **www.irs.gov** and click on **"Forms and Publications."***
- Funds carry over each year and grow on a tax-deferred basis

QUICK TIP

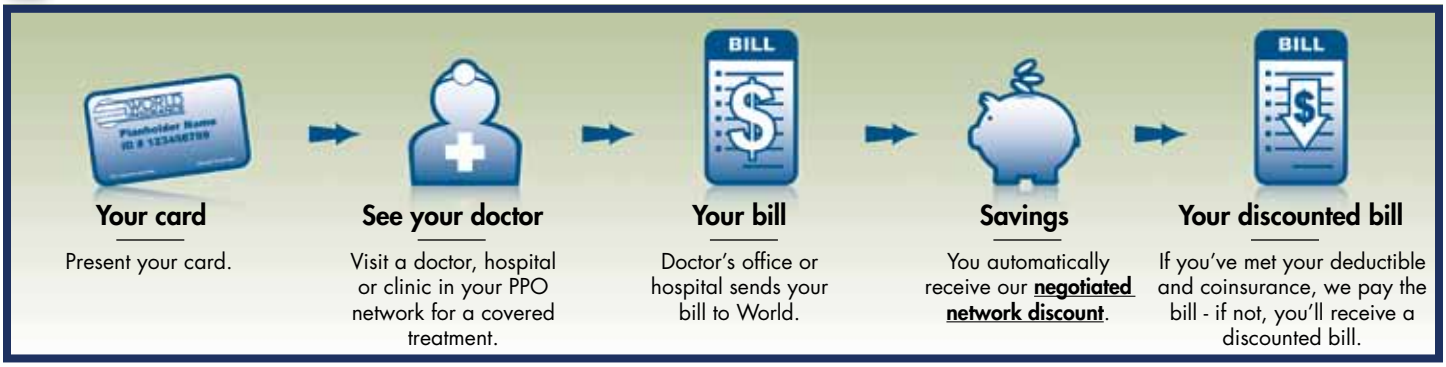
Use your HSA Account to pay medical expenses for you and your entire family

Even if they are not covered under your HSA-qualified plan, you can withdraw money tax free to pay for qualified health care costs for you and your tax-dependent family members.

World HSA Program

*The HSA Program is Easy to Use . . . and Gives You **2** Ways to Save*

1 ***Receive A Network Discount*** - You are eligible to receive a discount on health care bills – simply by having an HSA-qualified plan from World Insurance Company:



Your card
Present your card.

See your doctor
Visit a doctor, hospital or clinic in your PPO network for a covered treatment.

Your bill
Doctor's office or hospital sends your bill to World.

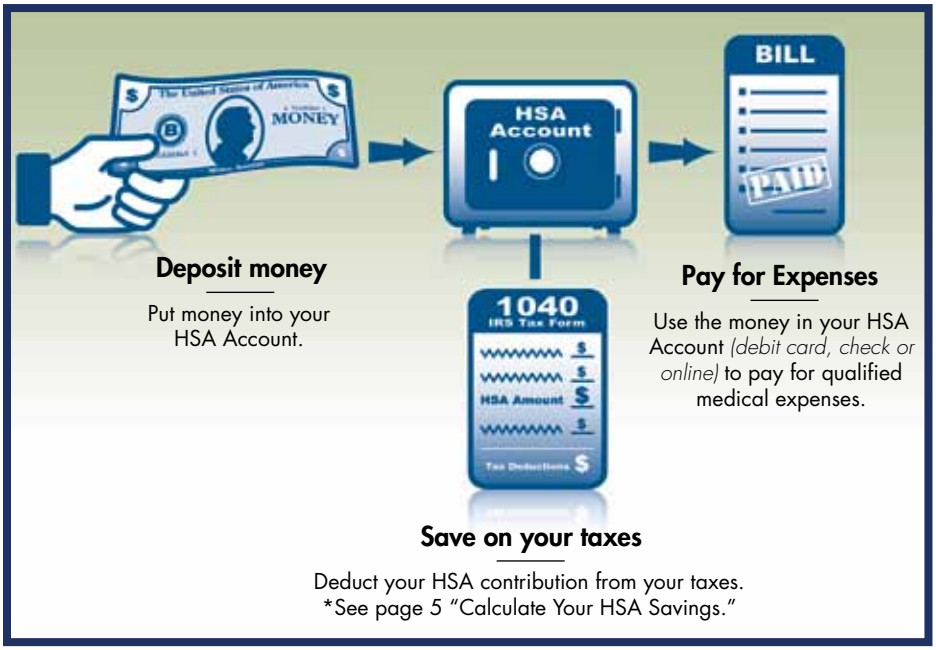
Savings
You automatically receive our **negotiated network discount**.

Your discounted bill
If you've met your deductible and coinsurance, we pay the bill - if not, you'll receive a discounted bill.

Then, instead of paying medical bills directly...

Pay your bill

2 ***Get Tax Savings*** - You'll receive 25%* tax savings by contributing funds to your HSA Account then paying your medical expenses.



Deposit money
Put money into your HSA Account.

Pay for Expenses
Use the money in your HSA Account *(debit card, check or online)* to pay for qualified medical expenses.

Save on your taxes
Deduct your HSA contribution from your taxes.
*See page 5 "Calculate Your HSA Savings."

QUICK TIP

Ways to fund your HSA account

1. Immediately establish your account with at least a minimum deposit.

2. Put money into your account when you need it - like when you have a doctor bill to pay - then pay your doctor from the account. ***OR . . .***

3. Put money in your account regularly, so it's there when you need it.

4. In 2011, you can contribute up to $3,050 annually for yourself, $6,150 for your family.

If you are between the ages of 55 and 65, you can contribute or **"catch up"** an additional amount of $1,000 in 2011.

How an HSA Can Reduce Your Income Taxes...

Get Triple Tax Savings with an HSA:

1. The money you contribute into your HSA Account is tax deductible.
2. Earnings in your account are tax deferred.
3. Withdrawals for qualified expenses remain tax free.

Calculate Your HSA Savings

Federal Tax Table

Taxable Income	Taxable Income	
Single	**Married Filing Jointly**	**Your Marginal Tax Bracket**
$0 - $8,375	$0 - $16,750	10%
$8,375 - $34,000	$16,750 - $68,000	15%
$34,000 - $82,400	$68,000 - $137,300	25%
$82,400 - $171,850	$137,300 - $209,250	28%
$171,850 - $373,650	$209,250 - $373,650	33%
$373,650 +	$373,650 +	35%

Based on 2010 tax table which is subject to change.
Source: Internal Revenue Service (www.irs.gov)

HSA Federal Income Tax Savings Calculator		*Example*
Step A	HSA Contribution Amount	$ *($1,000)*
Step B	Federal Marginal Tax Bracket	x *(.25)* %
Step C	Estimated Federal Income Tax Savings *(Multiply A x B)*	= $ *($250)*

You may also receive tax savings based on your state income tax.

HSA Features from HealthEquity®

We've chosen HealthEquity to provide you with extra HSA features. If you open a HealthEquity HSA Account, you'll have:

- ✓ **No Monthly Service Fee –** when you fund your account with $50 or more and your coverage remains in force
- ✓ **Access to Your Claims Online**
- ✓ **Account Management Tools –** and the ability to pay your provider online
- ✓ **Debit Card and Online HSA Account Access**
- ✓ **Various Investment Management Options**
- ✓ **Easy Health Assessment Program –** helps you get a better handle on your current health … and shows you smart ways to take better care of yourself
- ✓ **Symptom Checker –** helps you diagnose and understand a health-related condition
- ✓ **Care Guides –** understand the best way to care for various health conditions
- ✓ **Hospital Comparison Tool –** research and compare hospitals based on cost and quality

Signing up for a HealthEquity HSA Account is easy. Simply ask your agent.

As always, please consult your tax advisor regarding tax deductibility. This brochure outlines the advantages of HSAs and health insurance plans that are HSA-qualified in general and does not constitute tax advice.

HSA Account

An HSA Account is not a "use it or lose it" account. The money carries over year after year. All withdrawals for qualified medical expenses remain tax free, even in retirement.

You can choose to let your HSA funds grow for retirement. At age 65, you can take your money out for any reason. You pay only standard income tax on the amount you withdraw not used for qualified medical expenses.

Opening Your HSA Account

1. Choose an HSA-qualified health plan that best meets your individual needs.
2. Once your HSA-qualified plan is effective, open an HSA Account with HealthEquity or the financial institution of your choice.
3. Then fund your account in the manner you choose once your medical plan becomes effective.

World's HSA Comprehensive Plan

The HSA Plan Provides You:

Tax Advantages
The money you put into your HSA Account can be deducted each year from your taxes, and your HSA Account earns tax deferred interest. Plus, any money withdrawn from the account remains tax free as long as it's used to pay for qualified medical expenses.

Simplicity of a Single Family Deductible
The plan gives you one simple deductible for the entire family — no separate deductible for each family member.

No Lifetime Maximum
Your plan pays for all eligible medical expenses you incur in your lifetime.

2-Year Rate Protection
Help protect your rates for two years with this option. This kind of rate stability makes budgeting so much easier.

Preventive Services
To help you maintain your good health, many preventive services are paid at 100%.

Discounted Costs for Health Care
World has negotiated lower, discounted rates on covered health care treatment for you through our network of preferred providers.

Freedom To Choose Your Own Doctors
You can choose your own doctors and hospitals. Coverage is provided whether treatment is received inside or outside the network. We do encourage the use of network preferred providers whenever possible to ensure that you receive maximum benefits and cost savings.

This Coverage is Yours to Keep, Wherever You Go
When you purchase an individual health insurance plan it's not tied to your job. Your plan is yours to keep wherever you go.

Summary of Covered Expenses

Coverage On or Off the Job, 24 Hours a Day, 7 Days a Week

All benefits are per person and subject to deductible and coinsurance unless noted.

Covered Expenses	
Inpatient Hospital Confinement and Administered Services and Supplies	Covered
Outpatient Surgery and Administered Services and Supplies	Covered
Emergency Room Services and Supplies *You pay the $100 access fee (per visit). The access fee is waived if you are directly admitted to the hospital. (Access fee not applicable in Illinois.)*	Covered
Urgent Care Facility Services and Supplies	Covered
Office Visits	Covered
Preventive Services *As provided by the Patient Protection and Affordable Care Act of 2010, this benefit includes, but is not limited to, mammography, cervical and colorectal cancer screenings, childhood immunizations and cholesterol screenings.*	Covered *not subject to deductible or coinsurance*
Outpatient Prescription Drugs *Specialty drugs are always subject to deductible and coinsurance*	Covered
X-Ray & Laboratory Performed in a Physician's Office	Covered
Outpatient MRIs, CAT and PET Scans	Covered
Ground Ambulance and Air Ambulance	Covered
Durable Medical Equipment	Covered
Home Health Care *Up to 40 visits per calendar year.*	Covered
Hospice *Up to $100 per day on an outpatient basis; up to $200 per day on an inpatient basis with a $5,000 Lifetime Maximum Benefit.*	Covered
Skilled Nursing *Up to 60 days per calendar year.*	Covered
Radiation/Chemotherapy	Covered
Breast Reconstruction	Covered
Acute Rehabilitation	Covered
Organ Transplants	Covered
Outpatient Occupational, Physical and Speech Therapies *$50 per visit - up to $5,000 per calendar year for all therapies combined.*	Covered
Emergency Foreign Travel *$100,000 Lifetime Maximum Benefit.*	Covered
Treatment of Allergies *Up to $500 per calendar year.*	Covered
Treatment of Sleep Apnea *$2,000 Lifetime Maximum Benefit.*	Covered
Treatment of Growth Disorders *$15,000 Lifetime Maximum Benefit.*	Covered
Spinal Manipulation *(on an outpatient basis)* *Up to $50 per visit, and $500 per calendar year.*	Covered
Sterilization *$500 Lifetime Maximum Benefit. There is a 12-month waiting period.*	Covered

Customize Your Protection with These Options

All benefits are per calendar year and available for the HSA Comprehensive Plan.

Benefit Selections

The benefit selection options were designed with the HSA-qualified plan federal guidelines in mind. Please note, the out-of-network deductible is two times in-network.

Individual

Deductible	Coinsurance		In-network	Out-of-Pocket Amount*	Out-of-network *(subject to usual and customary)*	Out-of-Pocket Amount*
☐ $1,500 ☐ $3,050 ☐ $5,950	100%/0%	**You pay:**	0%	$0	20% of $22,250	$4,450
		We pay:	100%		80% of $22,250, then 100%	
☐ $1,500	80%/20%	**You pay:**	20% of $22,250	$4,450	40% of $22,250	$8,900
		We pay:	80% of $22,250, then 100%		60% of $22,250, then 100%	
☐ $3,050	80%/20%	**You pay:**	20% of $14,500	$2,900	40% of $14,500	$5,800
		We pay:	80% of $14,500, then 100%		60% of $14,500, then 100%	
☐ $1,500	60%/40%	**You pay:**	40% of $11,125	$4,450	50% of $17,800	$8,900
		We pay:	60% of $11,125, then 100%		50% of $17,800, then 100%	
☐ $3,050	60%/40%	**You pay:**	40% of $7,250	$2,900	50% of $11,600	$5,800
		We pay:	60% of $7,250, then 100%		50% of $11,600, then 100%	

Family

Deductible	Coinsurance		In-network	Out-of-Pocket Amount*	Out-of-network *(subject to usual and customary)*	Out-of-Pocket Amount*
☐ $3,000 ☐ $6,150 ☐ $7,500 ☐ $11,900	100%/0%	**You pay:**	0%	$0	20% of $44,500	$8,900
		We pay:	100%		80% of $44,500, then 100%	
☐ $3,000	80%/20%	**You pay:**	20% of $44,500	$8,900	40% of $44,500	$17,800
		We pay:	80% of $44,500, then 100%		60% of $44,500, then 100%	
☐ $6,150	80%/20%	**You pay:**	20% of $28,750	$5,750	40% of $28,750	$11,500
		We pay:	80% of $28,750, then 100%		60% of $28,750, then 100%	
☐ $7,500	80%/20%	**You pay:**	20% of $22,000	$4,400	40% of $22,000	$8,800
		We pay:	80% of $22,000, then 100%		60% of $22,000, then 100%	
☐ $3,000	60%/40%	**You pay:**	40% of $22,250	$8,900	50% of $35,600	$17,800
		We pay:	60% of $22,250, then 100%		50% of $35,600, then 100%	
☐ $6,150	60%/40%	**You pay:**	40% of $14,375	$5,750	50% of $23,000	$11,500
		We pay:	60% of $14,375, then 100%		50% of $23,000, then 100%	
☐ $7,500	60%/40%	**You pay:**	40% of $11,000	$4,400	50% of $17,600	$8,800
		We pay:	60% of $11,000, then 100%		50% of $17,600, then 100%	

* Does not include deductible, access fees, copayments or fees above the usual and customary amount.

Benefit Selections

Initial Rate Protection
The Initial Rate Period benefit locks in your initial premium (unless there is a change of residence, benefits, networks or covered persons, or we are required by law to change benefits or limitations in your coverage).

☐ 1 year initial rate period
☐ 2 year initial rate period *(available with deductibles of $3,000 or greater)*
(Only the 1 year initial rate period is available in Colorado.)

Preventive Services
Out-of-network preventive services are subject to deductible and coinsurance.

☐ No waiting period ☐ 6 month waiting period

Additional Benefits

Accident Expense Benefit
Pays first-dollar benefits for covered injuries right away, meaning you don't pay coinsurance or deductibles before benefits are paid. Benefit must be less than or equal to deductible.

☐ None ☐ $500 ☐ $1,000
☐ $1,500 ☐ $2,000 ☐ $2,500
☐ $3,000 ☐ $5,000 ☐ $10,000

Term Life
This benefit provides you (and your family if selected) with annually renewable term life insurance coverage. It may be converted to a World Insurance Company whole life policy. The term life rider is available to children age 19 - 27 if enrolled as a full-time student and financially dependent on you.

☐ None
☐ Individual - $15,000 ☐ Plus Family: Spouse $7,500
Child 14 days to 6 months $250
Child 6 months to 27 years $1,000
☐ Individual - $25,000 ☐ Plus Family: Spouse $12,500
Child 14 days to 6 months $500
Child 6 months to 27 years $2,000

Short-Term Convalescent Care Benefit
Pays a daily cash benefit to help with expenses if you're confined in a nursing home or assisted living facility. There is a 20-day waiting period before benefits will be paid. There is a 90-day lifetime maximum benefit.

☐ None
☐ Daily benefit of $_____ available in $10 increments from $100 to $200

Critical Illness Benefit
Cash benefits paid directly to you to spend as you wish if you're diagnosed with a critical illness. Benefits will be paid according to the schedule in your insurance contract. Refer to page 12 for further disclosure information.

☐ None ☐ $25,000

Accidental Death Benefit
Cash benefits paid in the event of a fatal accident.

☐ None ☐ $2,500 ☐ $5,000
☐ $7,500 ☐ $10,000 ☐ $15,000
☐ $25,000 ☐ $50,000 ☐ $100,000

Maternity
Helps pay pregnancy-related expenses such as prenatal care, delivery, newborn hospital costs and postpartum care after delivery. Benefits will be payable for pregnancies beginning after a 6-month waiting period.

☐ None
☐ $2,500 maternity deductible with 0% coinsurance
(the out-of-network deductible is $5,000)
(only available with 100%/0% coinsurance option when the deductible is $3,050 or less for individuals and $7,500 or less for families)

Exclusions & Limitations

Important Information About Your Plan

The exclusions and limitations listed below are typical, but your state may have slight differences. Please see your insurance contract for specific details.

- Coverage will not be provided for pre-existing conditions *(except as required by law)*; treatment, services and/or supplies not covered under the plan; or expenses incurred before the Issue Date or after the coverage terminates, except as provided.

No benefits will be provided for:

- pregnancy or normal childbirth, except for covered complications of pregnancy and prenatal care, or as specifically provided
- routine newborn or well-child care, except as specifically provided
- any drug *(including birth control pills)*, supply, treatment, or procedure used for the prevention of conception and/or childbirth
- services or supplies not needed for medical treatment, except as specifically provided
- expenses resulting from or engaging in an illegal act or occupation or committing or attempting to commit a felony
- illness or injury caused by or resulting from use of alcohol, illegal drugs, voluntary use of any controlled substance or use of prescription or over-the-counter drugs that are not taken in the dosage or purpose prescribed
- illness or injury resulting from participation in a high-risk activity for pay or commercial purposes including, but not limited to: skydiving, parachuting, bungee jumping, rodeo participation or organized contests of speed
- infertility treatment or any treatment to promote conception
- over-the-counter drugs, whether or not prescribed by a physician
- routine hearing care, artificial hearing devices or other means of enhancing, creating or restoring auditory comprehension
- routine vision care; glasses; contact lenses; vision therapy, exercise or training, except as specifically provided
- surgery to correct visual acuity including, but not limited to, LASIK and other laser surgery
- treatment of mental or nervous disorders, except as specifically provided
- expenses resulting from suicide, attempted suicide or intentional self-inflicted injury
- appliances for or medical or surgical expenses of the jaw
- dental care, except as specifically provided
- treatment of temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMD)
- treatment of hair loss, acne or rosacea and related conditions
- treatment or complications from treatment that are not medically necessary
- expenses incurred during military service or participation in war, whether declared or not
- breast reduction or augmentation or complications, except as specifically provided
- bunions; removal of corns, calluses or toenails; foot inserts; or orthopedic shoes or supportive devices for the feet
- cosmetic services, cosmetic peels, and reconstructive or plastic surgery that does not alleviate a functional impairment
- growth hormone therapy, except as specifically provided
- private duty nursing or having a standby provider
- services, supplies or treatment related to sex transformation, gender reassignment, or sexual function
- transportation, living expenses, services or supplies for personal convenience or custodial care, except as specifically provided
- treatment for a hernia, removal of adenoids and/or tonsils, varicose veins, hemorrhoids, middle ear disorders or disorders of the reproductive system for the first six months the coverage is in force unless deemed as emergency care
- treatment of a developmental delay, behavior modification or learning disabilities
- treatment payable or reimbursable by Medicare Parts A-D or other governmental program except Medicaid
- treatment, services or supplies for which no charge would be made if you did not have health insurance
- treatment, services or supplies provided by a person ordinarily living in your home, a member of your immediate family or your employer or business partner
- treatment, services or supplies received outside the United States, including drugs, except as specifically provided
- treatment, supplies or services that are defined as experimental or investigational
- weight modification programs or surgical treatment of obesity
- work-related illness or injury eligible for benefits under worker's compensation or similar laws

Additional exclusions and limitations apply to the outpatient prescription drug benefit. See your contract for details.

Questions and Answers About the World HSA Program

Q: I've applied for coverage. What happens next?

A: Once we receive your request for coverage, a representative may contact you to review the health questions you answered on the application. When your coverage is approved, your benefits begin immediately and you'll receive a kit in the mail that includes all the information you need to start using your plan – including your ID card. You'll receive your Express Scripts prescription drug card and Lab Card Select benefit card separately in the mail. When you use Lab Card Select, you'll receive additional discounts on your lab tests. *(Lab Card Select not available in North Carolina.)*

Q: With the World Insurance program, can I see the same doctor I see now?

A: Yes, you can choose any doctor you wish. However, you'll actually save money when using doctors within your Preferred Provider Organization (PPO) network because World Insurance Company has already negotiated special discounts with participating PPOs ... which means you'll pay less. If you use doctors outside the PPO network, you'll pay a greater share of covered expenses. In-network and out-of-network benefit differences are noted in the "Customize Your Protection" pages. In-network and out-of-network deductibles and coinsurance are accumulated separately.

Q: How do I find out if my doctor is part of the network?

A: Finding out if your doctor is in your PPO network is easy. You have 3 options …

Ask your doctor	Visit www.worldinsco.com	Call us toll free at 1-800-786-7557
Your doctor has a complete listing of all the PPO networks in which he or she participates	- Click on "Find a Provider" - Select your PPO network - Click on the network's link and search for your doctor	Customer Service representatives are available Monday thru Friday from 7:30 a.m. to 5 p.m. Central Time

Q: What happens if I have a serious illness or injury?

A: If you have a serious illness or injury requiring ongoing care, you can choose to receive additional help from a registered nurse through our Extra Care Program. Our registered nurses will respond to your health care needs and help coordinate care between you and your health care providers. Whether you want to take part in the Extra Care Program is completely up to you; you and your physician always remain in charge of your health care.

Q: What about my children? How long can they keep their World coverage?

A: Your children can keep coverage until they turn 26* at which time they can choose a similar World Insurance Company health plan of their own.

**In most states - please check your plan for specifics in your state.*

Q: What happens to my HSA if I leave my World Insurance Company health plan?

A: You own the HSA, so you keep the account, even if you change health insurance plans or insurance companies. The monthly service fee will now apply. If you're no longer enrolled in an HSA-qualified health plan, you are not eligible to make new contributions to your HSA, but you can continue to withdraw funds for qualified medical expenses.

Q: What should I do if I find an error on my hospital bill?

A: Simply call Customer Service. If you find an error of $50 or more on your hospital bill, we'll give you 50% of the savings, up to a $500 reward per hospital stay.

Disclosure Information

Access Fee
This is the dollar amount that you must pay each time you receive certain treatments, services and supplies. The access fee is subtracted from covered expenses before applying any deductible or coinsurance percentage. An access fee will not be reimbursed by us nor does it count toward satisfying any deductible, coinsurance percentage or other out-of-pocket limit.

Critical Illness
The lifetime benefit amount is payable at 100% for end-stage renal failure, blindness, heart attack, permanent paralysis, stroke, life-threatening cancer condition, loss of limbs and major organ transplant including: liver, kidney, lung, heart, pancreas or bone marrow; 25% is payable for first coronary artery bypass surgery and 10% for first angioplasty. Benefits are reduced by 50% when a covered insured turns age 70.

Preauthorization
You must call for authorization prior to inpatient and outpatient surgeries or any scheduled hospital or skilled nursing stay, home health or hospice care, or transplants or replacements. See your insurance contract for a complete list. Authorization is not required before treatment in an emergency situation; however, a later authorization is required. For human organ or bone marrow transplants or replacements, authorization is required at the time your doctor first indicates a transplant or replacement may be needed. Benefits may be reduced if preauthorization procedures are not followed or treatment is unauthorized. *(Provisions may vary by state.)*

Pre-existing Condition
This coverage is designed to pay for accidents that occur or sickness that first manifests itself after the date of issue. We will not pay for a pre-existing condition or disease for up to 12 months after issue which is not admitted on the application. Pre-existing condition means a condition for which medical advice was given or treatment was recommended by a physician within a 12-month period prior to the issue date of coverage for that covered person. Pre-existing conditions admitted on the application will be covered after the issue date unless excluded by name or specific description. Any false statement, misrepresentation or omissions in the application may result in benefits being denied or the contract being rescinded, subject to the Time Limit on Certain Defenses. The pre-existing conditions limitation does not apply to covered persons who are under 19 years of age. *(Provisions may vary by state.)*

Premiums and Renewability
You may renew the coverage for any covered person by paying the premiums as they come due. We may decline to renew the coverage for nonpayment of premiums, fraud, intentional misrepresentation, loss of eligibility, if we cancel the master policy, or if we discontinue all policies/certificates of the same type in a specific state or nationwide. See your insurance contract for additional details. Initial premium rates will remain unchanged from coverage issue date through the Initial Rate Period unless there is a change of residence, benefits, networks, or covered persons, or we are required by law to change benefits or limitations in your policy/certificate. These changes would result in modifications to your coverage and a change in premiums during the Initial Rate Period. We also reserve the right to change premium rates on any renewal date after the Initial Rate Period has expired.

Benefits and premiums will vary depending on plan, coverage choices and optional benefits you select. Applications are individually underwritten, and each person is assigned a rate class. Should a rate class premium change be necessary in the future, it will only be made if made on all forms in the same class as determined by us and not on an individual basis. At most ages, the premium will increase because a covered person is one year older. Such premium changes will accumulate but will not be made during the Initial Rate Period selected, unless a premium change is necessary during the Initial Rate Period because of a change of residence, benefits, networks, or covered persons, or because we are required by law to change benefits or limitations in your policy/certificate.

Other Coverage
If you have other coverage or become eligible for Medicare, benefits may be reduced *(not applicable to any life insurance benefits provided in conjunction with the plan)*. Plan provisions determine whether the benefits of this coverage are considered before or after those of the other coverage.

Usual and Customary
The Usual and Customary (U&C) amount is the charge for medical procedures, services and supplies World determines to be a reflection of the current statistical sampling of charges for medical procedures, services and supplies made in the same or comparable area. Charges in excess of the U&C are your responsibility and will not be paid by World. You are not subject to any U&C reduction when you use PPO providers.

State Variations

Please review these state variations which summarize the major differences in coverage by state. Refer to your insurance contract for complete details.

Alabama, Missouri and Virginia

- Preauthorization is not applicable.
- Spinal manipulation is covered the same as any other illness.
- Covered expenses include mammography, pelvic exams and pap smears, screenings for prostate and colorectal cancer, clinical cancer trials, bone mass measurements, newborn hearing screenings, childhood immunizations, treatment of alcoholism and chemical dependency *(limited benefit)*, and diabetes care and treatment.
- Contraceptive drugs are covered under the prescription drug benefit.

Arizona

- The pre-existing conditions definition is modified to be a condition for which medical advice was given or treatment was recommended within a 24-month period prior to the issue date of coverage; or that produced symptoms within a 12-month period prior to the issue date of coverage. Pre-existing conditions are not covered during the first 2 years. After 2 years, benefits are payable unless specifically excluded from coverage.
- Covered expenses include clinical cancer trials, mammograms and diabetes care and treatment.
- Contraceptive drugs are covered under the prescription drug benefit.

Colorado

- Only the $5,950 deductible for individuals and the $11,900 deductible for families are available.
- The home health care benefit is limited up to 60 visits per calendar year.
- Inpatient and outpatient hospice care (combined) is limited to 3 benefit periods and a lifetime maximum of $30,000.
- Bereavement support services are limited to $1,150.
- Preauthorization is not applicable.
- Covered expenses *not subject to deductible or coinsurance* include mammography, cervical and colorectal cancer screenings, childhood immunizations, cholesterol screening, alcohol misuse screening and behavioral counseling intervention and tobacco use screening and cessation interventions. A copayment will be applied for these services.
- Covered expenses also include cervical cancer vaccination, diabetes care and treatment, childhood supervision services *(not subject to deductible)*, prostate cancer screening *(not subject to deductible)*, clinical cancer trials, cleft lip and palate, early intervention services *(limited benefit)* and prosthetic devices.
- Any waiting periods for preventive services are not applicable.
- The optional maternity benefit is not available. Maternity is covered the same as any other illness.
- A health plan description form is available for review upon request.
- An Access Plan is maintained that gives details of how we make certain our insureds receive needed, appropriate care. If you would like to review the Access Plan for the preferred provider plan you selected, please call our Customer Service Center.

Delaware

- The pre-existing conditions definition is modified to be a condition for which medical advice was given, treatment was recommended or that produced symptoms within a 5-year period prior to the issue date of coverage.
- Covered expenses include screenings for ovarian, prostate and colorectal cancer, pap smears, mammography, diabetes care and treatment, child immunizations, lead poisoning screening, hearing screening for newborns, clinical cancer trials, serious mental illness and drug and alcohol dependency.
- Contraceptive drugs are covered under the prescription drug benefit.

Florida

- Preauthorization is not applicable.
- Spinal manipulation is covered the same as any other illness.
- Covered expenses include mammography, pelvic exams and pap smears, screenings for prostate and colorectal cancer, clinical cancer trials, bone mass measurements, newborn hearing screenings, treatment of alcoholism and chemical dependency *(limited benefit)*, diabetes care and treatment, dental anesthesia, diagnosis and treatment of osteoporosis, cleft lip and palate, newborn care and treatment, postmastectomy care and treatment of temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMD).
- Covered expenses *(not subject to deductible)* include children's preventive heath care services and immunizations.
- Contraceptive drugs are covered under the prescription drug benefit.

Illinois

- All access fees for eligible expenses are not applicable.
- Covered expenses include breast implant removal, inpatient treatment of alcoholism, dental anesthesia, mammography *(not subject to deductible, copayment, access fee or coinsurance if received in-network),* bone mass measurements, annual cervical or pap smear, screening tests and exams for colorectal, prostate and ovarian cancer, diabetes care and treatment, HPV vaccine and clinical breast exams.
- Contraceptive drugs are covered under the prescription drug benefit.

Indiana

- The pre-existing conditions definition is modified to be a condition for which medical advice, diagnosis, care or treatment was received or recommended within a 6-month period prior to the issue date of coverage.
- Covered expenses include mammography, clinical cancer trials, hearing aids, screening for colorectal and prostate cancer, cleft lip and palate treatment for children and treatment for a pervasive development disorder.

Iowa

- Covered expenses include mammography, prosthetic devices and diabetes care and treatment. Child health supervision services are covered *(not subject to deductible).*
- Contraceptive drugs are covered under the prescription drug benefit.

Kentucky

- Preauthorization is not applicable.
- Hospice treatment and spinal manipulation are covered the same as any other illness.
- The home health care benefit is limited up to 60 visits per calendar year.
- The pre-existing conditions definition is modified to be an illness or injury and related complications for which medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a provider or for which prescription drugs were prescribed during the 6-month period immediately prior to a covered person's application for coverage. Pre-existing conditions are not covered during the first 12 months. After 12 months, benefits are payable unless specifically excluded from coverage.
- Covered expenses include treatment or services rendered by ambulatory surgical centers, dental anesthesia, treatment of autism *(limited benefit)*, treatment of breast cancer by high-dose chemotherapy with bone marrow or stem cell transplantation, cochlear implants, diabetes care and treatment, diagnosis and treatment of endometriosis and endometritis, bone density testing, hearing aids *(limited benefit)*, mammography, pap smears, procedures relating to temporomandibular joint disorders (TMJ) and craniomandibular joint

State Variations

disorders (CMD) and screening for colorectal cancer.
- An optional mental disorders benefit is available which covers the treatment of mental illness in the same manner as any other illness.

Louisiana
- Spinal manipulation as well as outpatient occupational, physical and speech therapy is covered the same as any other illness.
- Preauthorization is not applicable.
- Covered expenses *not subject to deductible* include mammography, pap smears, childhood immunizations and prostate cancer screening.
- Covered expenses also include colorectal cancer screening, clinical cancer trials, diabetes care and treatment, bone mass measurement, dental anesthesia, cleft lip and palate, hearing aids for children, diagnosis and treatment of attention deficit/hyperactivity disorders *(limited benefit)* and prosthetic devices *(limited benefit)*.
- The term life benefit covers children beginning at birth.

Michigan
- The pre-existing conditions definition is modified to be a condition for which medical advice was given, treatment was recommended or received or that produced symptoms within a 6-month period prior to the issue date of coverage.
- Covered expenses include breast cancer diagnostic services and diabetes care and treatment.

Missouri *(see Alabama)*

Mississippi
- The pre-existing conditions definition is modified to be a condition for which medical advice, diagnosis, care or treatment was given, recommended or received within a 12-month period prior to the issue date of coverage; or that would have caused a person to seek medical advice, diagnosis, care or treatment within a 6-month period prior to the issue date of coverage.
- Spinal manipulation is covered the same as any other illness.
- Covered expenses include mammography, diabetes care and treatment, child health supervision services *(not subject to deductible, copayment or coinsurance)*, temporomandibular joint dysfunction and craniomandibular joint disorder *(limited benefit)* and treatment of alcoholism *(limited benefit)*.
- An optional mental illness benefit is available which covers 30 days/year for inpatient services, 60 days/year for partial hospitalization and 52 outpatient visits/year. Payment for inpatient services and partial hospitalization are provided on the same basis as any other condition. Payment for outpatient services is 50% of covered expenses with a maximum payment of $50/visit.

Nebraska
- Any access fees for eligible expenses other than for emergency room services and supplies are not applicable.
- The pre-existing conditions definition is modified to be a condition for which medical advice was given, treatment was recommended or that produced symptoms within a 2-year period prior to the issue date of coverage.
- Covered expenses include hearing tests for newborns, diabetes care and treatment, childhood immunizations *(not subject to coinsurance or copayments)*, mammograms, colorectal cancer screening, and treatment of temporomandibular joint disorders and craniomandibular disorders *(limited benefit)*.
- For a 90-day supply of a prescription from a participating mail order pharmacy, copays are three times the applicable drug copay.
- An optional alcoholism benefit is available which covers the treatment of alcoholism in the same manner as any other covered illness. Benefits are limited to 30 days of inpatient treatment coverage in a calendar year with a maximum of two inpatient treatment periods. Outpatient treatment is limited to 60 visits.

Nevada
- The pre-existing conditions definition is modified to be a condition for which medical advice, diagnosis, care or treatment was recommended or received during the 6-month period prior to the issue date of coverage. Pre-existing conditions are not covered during the first 2 years. After 2 years, benefits are payable unless specifically excluded from coverage.
- Covered expenses include clinical cancer trials, mammography, diabetes care and treatment, pap smears, screening for colorectal and prostate cancer, dental anesthesia, temporomandibular joint treatment *(limited benefit)*, alcohol or drug abuse and severe mental illness.
- Contraceptive drugs are covered under the prescription drug benefit.

North Carolina
- Preauthorization is not applicable.
- The pre-existing conditions definition is modified to be a condition for which medical advice, diagnosis, care or treatment was given or recommended within a 12-month period prior to the issue date of coverage. Pre-existing conditions are not covered during the first 12 months of coverage. After 12 months, benefits are payable unless specifically excluded from coverage.
- Covered expenses include screening for prostate, colorectal, ovarian and cervical cancer, diabetes care and treatment, dental anesthesia, bone mass measurements, mammography, procedures to treat any bone or joint of the jaw, face or head *(limited benefit)*, clinical trials, hearing screening for newborns and treatment of mental illnesses.
- Contraceptive drugs are covered under the prescription drug benefit.
- The optional maternity benefit is not available.

North Dakota
- The pre-existing conditions definition is modified to be an illness or injury and related complications for which medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a provider or for which prescription drugs were prescribed during the 6-month period immediately prior to the issue date of coverage.
- Covered expenses include screening for prostate cancer, treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder (CMD) *(limited benefit)*, dental anesthesia and mammography.
- The optional maternity benefit is not available. Maternity benefit coverage that covers a normal pregnancy and childbirth the same as any other illness is available. Ask your agent for details.

Ohio
- The optional term life benefit is not available.
- The maternity waiting period for the optional maternity benefit is 180 days.
- Covered expenses include alcoholism treatment *(limited benefit)*, mammography, child health supervision services, biologically based mental illness and cervical cancer screening.

Oklahoma
- The optional term life benefit is not available.
- Preauthorization is not applicable.
- The pre-existing conditions definition is modified to be a condition for which medical advice was given, treatment was recommended or that produced symptoms within a 5-year period prior to the issue date of coverage. Pre-existing conditions are not covered during the first 2 years of coverage. After 2 years, benefits are payable unless specifically excluded from coverage.
- Covered expenses include bone density tests, mammography *(not subject to deductible, coinsurance or copayments)*, diabetes care and treatment, childhood immunizations *(not subject to deductible, coinsurance or copayments)*, postmastectomy care, dental anesthesia, prostate screening *(not subject to deductible)*, colorectal exams, child health supervision services, hearing screening/aids for children.

Pennsylvania
- Preauthorization is not applicable.
- The pre-existing conditions definition is modified to be a condition for which medical advice was given, treatment was recommended or that produced

symptoms within a 5-year period prior to the issue date of coverage. Pre-existing conditions are not covered during the first 2 years. After 2 years, benefits are payable unless specifically excluded from coverage.
- Covered expenses include postmastectomy care, mammography and diabetes care and treatment.
- Covered expenses *(not subject to deductible)* include gynecological, pelvic and breast exams, pap smears, and child health supervision services.

South Carolina
- The pre-existing conditions definition is modified to be a condition for which advice was given or treatment recommended within a 5-year period prior to the issue date of coverage; or that produced symptoms within a 12-month period prior to the issue date of coverage. Pre-existing conditions will not be covered during the first 2 years of coverage.
- Covered expenses include mammography, pap smears, prostate cancer screening, postmastectomy care, cleft lip and palate and diabetes care and treatment.
- An optional mental/nervous disorder benefit is available which covers the care and treatment of psychiatric conditions up to $2,000 per calendar year for each covered person up to a lifetime maximum of $10,000.

South Dakota
- Covered expenses include prostate cancer screening, diabetes care and treatment, mammography, dental anesthesia and treatment and diagnosis of biologically-based mental illnesses.
- An optional alcoholism benefit is available which covers the primary and outpatient treatment of alcoholism the same as any other illness. Benefits are limited to 30 days of care in any 6-month period and will not exceed a lifetime maximum of 90 days per covered person.

Tennessee
- Spinal manipulation is covered the same as any other illness.
- The pre-existing conditions definition is modified to be a condition for which medical advice was given, treatment was recommended or that which produced symptoms within a 5-year period prior to the issue date of coverage. Pre-existing conditions are not covered during the first 2 years. After 2 years, benefits are payable unless specifically excluded from coverage.
- Covered expenses include autism spectrum disorders, diabetes care and treatment, dental anesthesia, bone mass measurements, mammography, screening for prostate and colorectal cancer, bone marrow transplants, chlamydia screening and audiologist and speech pathologist services.
- The optional maternity benefit is payable for deliveries occurring after the maternity waiting period.

Texas
- Covered expenses also include mammograms, screenings for cervical, prostate and colon cancer, newborn hearing screenings *(not subject to deductible)*, childhood immunizations *(not subject to deductible, copayment or coinsurance)*, diabetes care and treatment, prosthetic devices, clinical cancer trials, reconstructive surgery for craniofacial abnormalities caused by congenital defects for covered dependents 18 or younger, osteoporosis treatment, care and treatment of acquired brain injuries and minimum required hospital stays following a mastectomy.
- The optional maternity benefit is not available.
- The home health care benefit is limited up to 60 visits per calendar year.
- Preauthorization is not applicable.
- Contraceptive drugs are covered under the prescription drug benefit.
- The optional term life benefit amounts for child coverage are $700 and $1,400.
- Any waiting periods for preventive services are not applicable.
- The optional short-term convalescent care benefit is not available.
- An optional mental or emotional illness benefit is available which covers up to 45 days/year for inpatient care/treatment and up to 60 visits/year for outpatient treatment. Treatment at a day treatment facility will be considered equal to one-half of one day of treatment for inpatient care/treatment. Each 2 days of treatment for children and adolescents in a residential treatment center or crisis stabilization unit are considered to equal 1 day of treatment for inpatient care/treatment.
- An optional rehabilitative and habilitative therapy benefit is available which covers the following therapies for children from birth to age 3 with developmental delays: occupational, physical and speech therapy evaluation and services as well as dietary or nutritional evaluations. Benefits under this rider are not subject to the lifetime maximum but are subject to deductibles and coinsurance amounts.

This is a Consumer Choice Health Benefit Plan. It does not provide, either in whole or in part, state-mandated health benefits normally required in Texas. This plan may provide you more affordable insurance; however, may also provide you with fewer health benefits than those normally included as state-mandated benefits.

A plan is available which covers all state-mandated benefits. Ask your agent for details.

The state-mandated benefits not included are the following: Medically necessary care and treatment of hearing loss or impairment of speech or hearing, medically necessary diagnostic and/or surgical treatment of temporomandibular joint dysfunction (TMJ), telemedicine medical services or telehealth services, medically necessary inpatient or outpatient treatment of serious mental illness, care and treatment of chemical dependency, and certain tests for early detection of cardiovascular disease.

Virginia *(see Alabama)*

West Virginia
- The pre-existing conditions definition is modified to be a condition for which advice was given, treatment recommended or that produced symptoms within a 2-year period prior to the issue date of coverage. Pre-existing conditions will not be covered during the first 2 years of coverage.
- The home health care benefit is limited up to 100 visits per calendar year.
- Covered expenses include mammography, pap smears, screening for cervical and colorectal cancer, child immunization services *(not subject to deductible or copayment)*, clinical cancer trials, diabetes care and treatment, dental anesthesia, hearing screening for newborns, and temporomandibular and craniomandibular disorders.
- Contraceptive drugs are covered under the prescription drug benefit.
- An optional mental or nervous disorder benefit is available which covers at least 45 consecutive days in any calendar year as an inpatient in mental hospital. Benefits as an inpatient in a general hospital is covered the same as any other illness. Outpatient benefits pays 50% of covered expenses, not to exceed $500 in a 12-month period.

Wisconsin
- Covered expenses include kidney disease treatment, including transplants *(limited benefit)*, child immunizations *(not subject deductible or coinsurance)*, autism spectrum disorders *(limited benefit)*, lead poisoning screening, mammography, temporomandibular disorders *(limited benefit)*, clinical cancer trials, diabetes care and treatment, mental or nervous disorders and alcoholism or substance abuse *(limited benefit)*.
- The exclusion for spinal manipulation is removed.

Wyoming
- The pre-existing conditions definition is modified to be a condition for which advice was given or treatment recommended within a 6-month period prior to the issue date of coverage.
- Covered expenses include clinical cancer trials, diabetes care and treatment and comprehensive adult wellness benefits *(limited benefit not subject to deductible)*.

Your Satisfaction is Guaranteed

You have our guarantee that your protection through World Insurance Company's program is of the highest quality and gives you customized benefits at an economical price. If you are not 100% satisfied with your coverage, you may return your policy/certificate of coverage within 10 days of receiving it and your money will be promptly refunded.

In AL, AZ, DE, FL, IL, IN, IA, MI, MO, MS, NE, NV, NC, OH, OK, PA, SC, TN, TX, VA, WI and WY available to members of National Consumer Alliance.

This brochure provides a description of some of the important features of your plan. The benefits, exclusions and limitations listed are typical, but your state may have slight differences. The insurance contract sets forth in detail the rights and obligations of both you and the Company. For further details about this or other available coverage, please contact your agent. Plan availability varies by state.

This is a solicitation of insurance and an agent may contact you.

Forms: AC4800W, AC4800W-OK, AC4800W-PA, AC4800W-TN, AC4800W-PPO, AC4801W, A4800W-I, A4808W-I
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