WORLD INSURANCE

WorldCARE℠

Basic Medical Plan

F4251

Individual Health Insurance Solutions

That You Can Customize to Meet Your Needs

When you choose the *WorldCARE℠ Basic Medical* insurance plan from World Insurance Company, you'll get more than solid, reliable health 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 guarantees up to 3 years

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

- **We developed a flexible health care** 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** - select only the benefits you want

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 (January 2008) 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

WorldCARE Benefit Highlights

Basic Medical Plan

3-Year Rate Guarantee

Your rates will not change for three years if you choose this option. One- and two-year options are also available. This kind of rate stability makes budgeting so much easier.

Hospital Coverage

Your plan covers inpatient hospital stays and pays for related services and supplies.

Wellness Benefits

To help you maintain your good health, you may choose a benefit that helps pay for routine physicals, screenings and immunizations.

Good Health Refund

Get a portion of your premium refunded for every consecutive year that you don't have a claim (Wellness Services are excluded). You'll receive a 5% refund of your premium the first year, 10% the second year and a 15% refund of your premium your third and additional consecutive years. Not available in all states. See your contract for details.

Discounted Costs for Health Care

World has negotiated lower, discounted rates on 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.

Lifetime Maximum

Choose to have your plan pay up to $2 million for all eligible medical expenses you incur in your lifetime.

Our commitment to you goes beyond your insurance coverage . . .

At World, every health insurance plan you choose automatically includes extra privileges to help you make better health care decisions. We've chosen HealthEquity® to provide you with all of these services at no cost to you … and some of these extra privileges include:

- **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

Take advantage of these services by activating your free account. Simply log on to **www.healthequity.com** once your coverage is issued.

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.

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 $500 access fee (per visit). The access fee is waived if you are admitted to the hospital. (Access fee not applicable in Illinois.)*	Covered
Urgent Care Facility Services and Supplies	Covered
Office Visits	Not Covered *unless you select a benefit*
Wellness Services	Not Covered *unless you select a benefit*
Outpatient Prescription Drugs	Not Covered *unless you select a benefit*
Outpatient X-Ray & Lab	Not Covered *unless you select a benefit*
Outpatient MRIs, CAT Scans and PET Scans	Not Covered *unless you select a benefit*
Ground Ambulance and Air Ambulance *Air Ambulance Benefit up to $10,000 per calendar year.*	Covered
Durable Medical Equipment	Covered
Home Health Care *Up to 40 visits per 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 *When performed in a Center of Excellence - $1,000,000 per transplant maximum ($500,000 when the Policy Lifetime Maximum of $500,000 is selected). When not performed in a Center of Excellence - $100,000 Lifetime Maximum Benefit.*	Covered
Outpatient Occupational, Physical and Speech Therapies	Not Covered
Emergency Foreign Travel	Not Covered
Treatment of Allergies	Not Covered
Treatment of Sleep Apnea	Not Covered
Treatment of Growth Disorders	Not Covered
Spinal Manipulation *(on an outpatient basis)*	Not Covered
Sterilization	Not Covered

Customize Your Protection with These Options

All benefits are per person, per calendar year.

☐ *Indicates this benefit is included in your plan. Customize your benefits if you choose.*

Benefit Selections

Deductible
This is the amount you pay for covered medical expenses before your coinsurance is applied. Only three deductibles must be satisfied per family per year.

You pay: ☐ **$1,000** ☐ **$1,500** ☐ **$2,500** ☐ **$5,000** ☐ **$10,000** ☐ **$15,000** ☐ **$20,000** ☐ **$25,000**
(Your deductible for out-of-network is two times the in-network amount)

Coinsurance after deductible			**In-network**	**Out-of-network** *(subject to usual and customary)*
75%/25% option	☐	**You pay:**	25% of $10,000	50% of $20,000
		We pay:	75% of $10,000, then 100%	50% of $20,000, then 100%
	☐	**You pay:**	25% of $20,000	50% of $40,000
		We pay:	75% of $20,000, then 100%	50% of $40,000, then 100%
	☐	**You pay:**	25% of $50,000	50% of $100,000
		We pay:	75% of $50,000, then 100%	50% of $100,000, then 100%
50%/50% option	☐	**You pay:**	50% of $10,000	50% of $20,000
		We pay:	50% of $10,000, then 100%	50% of $20,000, then 100%
	☐	**You pay:**	50% of $20,000	50% of $40,000
		We pay:	50% of $20,000, then 100%	50% of $40,000, then 100%
	☐	**You pay:**	50% of $50,000	50% of $100,000
		We pay:	50% of $50,000, then 100%	50% of $100,000, then 100%

Lifetime Maximum
The maximum amount the plan pays for all eligible medical expenses you incur in your lifetime.

☐ $500,000 ☐ $1,000,000 ☐ $2,000,000

Initial Rate Guarantee
A benefit that locks in your initial premium (as long as benefit selections, area of residence and covered persons remain the same).

- ☐ 1 year rate guarantee
- ☐ 2 year rate guarantee *(available on deductibles of $2,500 or greater)*
- ☐ 3 year rate guarantee *(available on deductibles of $2,500 or greater)*

Office Visits Benefit
Covers the examination performed during your in-network office visit. Out-of-network office visits are subject to the out-of-network deductible and coinsurance.

- ☐ None
- ☐ Subject to your plan's deductible and coinsurance
- ☐ $30 copay with a 3 visit calendar year maximum, then subject to your plan's deductible and coinsurance

Wellness Services Benefit
Helps pay for routine physicals, screenings and immunizations.

- ☐ None
- ☐ $30 copay, then up to $300 per calendar year *(paid on a first-dollar basis and subject to a 6-month waiting period)*
- ☐ $50 copay, then $200 1st calendar year; $400 2nd calendar year; $600 3rd calendar year and thereafter *(paid on a first-dollar basis and subject to a 12-month waiting period)*

Outpatient X-Ray & Lab Benefit
Helps pay for laboratory, diagnostic and radiological exams.

- ☐ None
- ☐ Subject to your plan's deductible and coinsurance
- ☐ Up to $1,000 per calendar year *(paid on a first-dollar basis)*

Outpatient MRIs, CAT Scans and PET Scans

- ☐ None
- ☐ Benefits paid on a first-dollar basis
- ☐ $250 access fee per test, then subject to your plan's deductible and coinsurance; up to $1,000 per calendar year *(access fee not applicable in Illinois and Nebraska)*

Customization Options Continued Next Page →

Customize Your Protection with These Options

All benefits are per person, per calendar year.

☐ *Indicates this benefit is included in your plan. Customize your benefits if you choose.*

Benefit Selections Continued

Outpatient Prescription Drug Benefit
Helps pay for drugs prescribed to you by a doctor or in a doctor's office.

If you select a copay benefit, a 90-day supply from a participating mail order pharmacy is available for two times the applicable copay.

Specialty drugs are subject to deductible and coinsurance unless the $0 copay Generic only benefit option is chosen.

		Generic Drugs	Brand Name Drugs	
			On Formulary	Not on Formulary
☐	None			
☐	Subject to your plan's deductible and coinsurance *(available if deductible is $5,000 or greater)*			
☐	**You pay:**	$0 copay	100% - A drug discount card is provided	100% - A drug discount card is provided
	We pay:	100%	0%	
☐	**You pay:**	$10 copay OR 20% of the cost of the drug, whichever is greater	$1,000 deductible $30 copay OR 50% of the cost of the drug, whichever is greater	$50 copay OR 50% of the cost of the drug, whichever is greater
	We pay:	100% after that		

Premium Reduction Options

(Selecting one of these options may reduce other stated benefit maximums during a calendar year. The total of the selected Inpatient and Outpatient Facility Maximums may not exceed the selected Calendar Year Maximum.)

Calendar Year Maximum
The maximum amount the plan pays for all eligible medical expenses you incur in a calendar year.
☐ $250,000

Inpatient Facility Calendar Year Maximum
The maximum amount the plan pays for inpatient facility expenses.
☐ $250,000

Outpatient Facility Calendar Year Maximum
The maximum amount the plan pays for outpatient facility expenses.
☐ $15,000

Additional Benefits

Accident Expense Benefit
Pays first-dollar benefits for covered injuries right away. First dollar means 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. The Lifetime Maximum Benefit is 90 days.
☐ None
☐ Daily benefit of $____ available in $10 increments from $100 to $200

Critical Illness Benefit
Cash benefits paid directly to you upon diagnosis of a critical illness. Benefits will be paid according to the schedule in your insurance contract. Available to applicants age 19 or older. Refer to page10 for further disclosure information.
☐ None ☐ $25,000

Accidental Death Benefit
Cash benefits paid for a covered person 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
☐ $10,000 deductible and 50% coinsurance of $20,000
(the out-of-network deductible is $20,000)

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; 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, prenatal care or normal childbirth, except for covered complications of pregnancy 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
- routine physical exams or other 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)
- smoking cessation programs
- 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
- 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, 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
- treatment, services or supplies received outside the United States, including drugs, except as specifically provided
- sterilization or reversal of sterilization, except as specifically provided
- spinal manipulation, except as specifically provided
- outpatient occupational, physical and speech therapy, except as specifically provided
- treatment of allergies, except as specifically provided
- treatment of growth disorders, except as specifically provided
- treatment of sleep apnea, except as specifically provided

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

Questions and Answers About the Basic Medical Plan

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.

Q: I've been approved for coverage. What happens now?

A: 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 WorldCARE 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 when I need to fill a prescription?

A: Present your Express Scripts card at a participating pharmacy. You can find a list of participating pharmacies – along with your plan's formulary list – at ***www.express-scripts.com***. "Formulary" is a list of eligible outpatient drugs.

Q: What's the difference between Generic and Brand Name drugs? How do Specialty drugs fit in?

A: Generic drugs have the same active ingredients as Brand Name drugs – but generally cost less. Both Generic and Brand Name drugs are approved by the Food & Drug Administration. Specialty drugs are high-cost medications and biologicals that are often used to treat complex clinical conditions. They usually require close management by a physician because of their potential side effects and need for frequent dosage adjustments.

Q: I've heard a lot lately about stores offering $4 generic prescriptions. How does this apply to my plan?

A: You will pay $4. You will not pay more just because your copay or coinsurance amount is higher.

Q: I keep hearing a lot about "Wellness" benefits. What are they – and are they included in my plan?

A: Wellness benefits include things like routine physicals, screenings and immunizations. If you choose, you can include these in your plan. Amounts paid will depend on the specific benefit amount you choose.

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 WorldCARE coverage?

A: Your children can keep coverage until they turn 27 as long as they are unmarried, enrolled full-time in an accredited school and financially dependent on you. Otherwise, coverage will end on their 19th birthday.* Your children 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 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.

Q: Is there any way I can lower my health care costs?

A: Yes, there are a number of ways to cut costs, such as …

Premium:

- Choosing a higher deductible or higher coinsurance in exchange for a lower rate.
- Considering a premium reduction option in the "Customize Your Protection" pages.

Health Care:

- Using the online prescription drug finder ***(www.express-scripts.com)*** to locate lower-priced alternatives, like generics.
- Using the online medical library ***(www.healthequity.com)*** to find information on common health risks, preventive care and treatment so you can live healthier.

Q: Can I change my benefits at a later date?

A: Many benefit changes can be made with just a phone call to Customer Service. However, for some changes, like lowering your deductible, you may have to complete another application process.

Disclosure Information and State Variations

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, 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 insure 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. *(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, 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 are guaranteed from coverage issue date for the Rate Guarantee Period you select so long as your area of residence, benefit selections and covered persons remain the same. We reserve the right to change premium rates on any renewal date after the Rate Guarantee Period chosen has expired. Benefits and premiums will vary depending on plan, coverage choices and optional benefits which 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 Rate Guarantee Period selected.

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 and devices are covered under the prescription drug benefit.
- In AL only, the Good Health Refund is not available.

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.

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.
- Contraceptives 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 and devices 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, 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 and devices and prescription drugs for cancer 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, 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 and diabetes care and treatment. Child health supervision services are covered *(not subject to deductible)*.
- Contraceptive drugs and devices are covered under the prescription drug benefit.

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)*.
- Cancer drug therapy is covered under the prescription drug benefit.
- An optional mental illness rider 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 rider 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.
- The Good Health Refund is not available.

New Mexico
- The Home Health Care benefit is limited to up to 100 visits per calendar year.
- Covered expenses include clinical cancer trials, mammography, screening for colorectal and cervical cancer, dental anesthesia, diabetes care and treatment, treatment of temporomandibular joint disorders and craniomandibular disorders, childhood immunizations, circumcision for covered newborn males, and hearing aid and services for children *(limited benefit)*.
- The pre-existing conditions definition is modified to be a condition for which advice was given, treatment was recommended or that produced symptoms within a 6-month period prior to the issue date of coverage. Pre-existing conditions are not covered during the first 6 months of coverage. After 6 months, benefits are payable unless specifically excluded from coverage.
- Contraceptive drugs are covered under the prescription drug benefit.
- An optional alcoholism benefit rider is available which covers 30 days in an alcohol dependency treatment center and 30 outpatient visits per calendar year for alcohol dependency treatment.

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 and devices are covered under the prescription drug benefit.
- The Optional Maternity Benefit is not available.

Ohio
- The Optional Term Life Benefit is not available.
- The maternity waiting period for the Optional Maternity Expense Benefit is 180 days.
- Covered expenses include alcoholism treatment *(limited benefit)*, mammography, child health supervision services, biologically based mental illness and cervical cancer screening.
- The Good Health Refund is not available.

Oklahoma
- The Optional Term Life Benefit is not available.
- Organ transplant benefits are not reduced if not performed at a Center of Excellence.
- 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 & 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 rider 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.

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.

Virginia *(see Alabama)*

Wisconsin
- The pre-existing conditions definition is modified to be a condition for which advice was given, treatment recommended or produced symptoms within a 5-year 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 kidney disease treatment, including transplants *(limited benefit)*, child immunizations *(not subject deductible or coinsurance)*, 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)*.

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