

ExpressMed



ExpressMed Premier

*Comprehensive coverage
with cost-saving features*

ExpressMed Premier Plus

*Comprehensive coverage
with unique benefit features*

ExpressMed

Individual Health Insurance Solutions That You Can Customize to Meet Your Needs

When you choose an **ExpressMed** comprehensive major medical insurance plan, you'll get more than solid, reliable health coverage, you'll also get the right balance of **cost, coverage** and **convenience**.

Plans to fit every need and budget

Choose from two easy-to-understand individual health plans: *ExpressMed Premier* and *ExpressMed Premier Plus*. These plans are designed to help individuals and families pay for medical expenses, prescription drugs, office visits and wellness services. And it's easy to customize your plan with options to meet your needs and budget.

ExpressMed Premier

Prescription Drug Coverage
Office Visits

- \$50 copay

Wellness Services Options

- Up to \$250 per calendar year
(subject to deductible and coinsurance)
- No copay, up to \$300 per calendar year

ExpressMed Premier Plus

Prescription Drug Coverage
Office Visits

- First two copays waived, then \$50 copay

Wellness Services Options

- \$50 copay, up to \$300 per calendar year
- No copay, up to \$500 per calendar year



Both Plans Include These Value Added Benefits ...

- **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.
- **Wellness Benefits**
To help you maintain good health, the plans help pay for routine physicals, screenings and immunizations.
- **Lifetime Maximum**
Choose to have your plan pay \$1 million, \$3 million or \$5 million for all eligible medical expenses you incur in your lifetime.
- **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.

It's easy to apply ... we take care of the paperwork

- Convenient 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

ExpressMed

About Preferred Provider Organization (PPO) Plans

You'll save money when using doctors within your PPO network because World Insurance Company (World) has negotiated **special discounts ... which means you'll pay less.**



Freedom to choose your own doctors

Coverage is provided whether treatment is received inside or outside the network. We do encourage the use of network providers whenever possible to ensure that you receive maximum benefits and cost savings.

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.

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

Ask your doctor

Your doctor has a complete listing of all the PPO networks in which he or she participates

Visit www.worldinsco.com

- Click on "Find a Provider"
- Select your PPO network
- Click on the network's link and search for your doctor

Ask your agent

Your agent will be happy to give you the PPO network information you need

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.

Premier and Premier Plus 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 otherwise indicated.

Covered Expenses	Premier	Premier Plus
Inpatient Hospital Confinement and Administered Services and Supplies	Covered	Covered
Outpatient Surgery and Administered Services and Supplies	Covered	Covered
Emergency Room Services and Supplies <i>You pay the \$150 access fee (per visit). The access fee is waived if you are admitted to the hospital.</i>	Covered	Covered on a first-dollar basis; up to \$1,000 per calendar year after access fee
Urgent Care Facility Services and Supplies	Covered	Covered
Office Visits <i>No calendar year maximum.</i>	\$50 copay	\$50 copay, the first two copays are waived each calendar year
Wellness Services	Covered up to \$250 per year <i>(subject to deductible and coinsurance) with alternate benefit selection available</i>	\$50 copay, then covered on a first-dollar basis; up to \$300 per calendar year <i>(there is a 6-month waiting period) with alternate benefit selection available</i>
Outpatient Prescription Drugs	Generic drugs: \$0 deductible with \$15 copay or 20%, Brand Name drugs: formulary \$30 copay or 50%, non-formulary \$45 copay or 50%, \$500 calendar year Brand name drug deductible <i>with alternate benefit selection available</i>	Generic drugs: \$0 deductible with \$10 copay or 20%, Brand Name drugs: formulary \$30 copay or 50%, non-formulary \$50 copay or 50%, \$200 calendar year Brand name drug deductible
Outpatient X-Ray & Lab	\$50 copay per test; up to \$200 per test	\$25 copay per test, up to \$200 per test
Outpatient MRIs, CAT Scans and PET Scans	Covered	Covered on a first-dollar basis; up to \$1,000 per test
Ground Ambulance and Air Ambulance <i>Air Ambulance Benefit up to \$10,000 per calendar year.</i>	Covered	Covered
Durable Medical Equipment	Covered	Covered
Home Health Care <i>Up to 40 days per calendar year.</i>	Covered	Covered
Hospice <i>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.</i>	Covered	Covered
Skilled Nursing <i>Up to 60 visits per calendar year.</i>	Covered	Covered
Radiation/Chemotherapy	Covered	Covered
Breast Reconstruction	Covered	Covered
Acute Rehabilitation	Covered	Covered
Organ Transplants <i>When performed in a Center of Excellence - \$1,000,000 per transplant maximum. When not performed in a Center of Excellence - \$100,000 Lifetime Maximum Benefit.</i>	Covered	Covered
Outpatient Occupational, Physical and Speech Therapies <i>\$50 per visit; up to \$2,000 per calendar year for all therapies combined.</i>	Covered	Covered
Emergency Foreign Travel <i>\$100,000 Lifetime Maximum Benefit.</i>	Covered	Covered
Treatment of Allergies <i>Up to \$500 per calendar year.</i>	Covered	Covered
Treatment of Sleep Apnea <i>\$2,000 Lifetime Maximum Benefit.</i>	Covered	Covered
Treatment of Growth Disorders <i>\$15,000 Lifetime Maximum Benefit.</i>	Covered	Covered
Spinal Manipulation (on an outpatient basis) <i>Up to \$50 per visit and \$500 per calendar year.</i>	Covered	Covered
Sterilization <i>\$500 Lifetime Maximum Benefit. There is a 12-month waiting period.</i>	Covered	Covered

Premier

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: \$500 \$1,000 \$1,500 \$2,000 \$2,500
 \$3,500 \$5,000 \$7,500 \$10,000 \$25,000

(Your deductible for out of network is two times the in-network amount)

The deductible must be \$2,500 or greater on the 100% plan

The deductible must be \$1,000 or greater on the 80% plan

Coinsurance after deductible		In-network		Out-of-network	
100%/0%	<input type="checkbox"/>	You pay:	0%	20% of \$10,000	
		We pay:	100%	80% of \$10,000, then 100%	
80%/20%	<input type="checkbox"/>	You pay:	20% of \$15,000	40% of \$30,000	
		We pay:	80% of \$15,000, then 100%	60% of \$30,000, then 100%	
50%/50%	<input type="checkbox"/>	You pay:	50% of \$15,000	50% of \$30,000	
		We pay:	50% of \$15,000, then 100%	50% of \$30,000, then 100%	

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 always subject to deductible and coinsurance.

		Generic	Brand Name Drugs	
			On Formulary	Not on Formulary
<input type="checkbox"/>	You pay:	\$15 copay OR 20% of the cost of the drug, whichever is greater	\$500 deductible	
	We pay:	100% after that
<input type="checkbox"/>	You pay:	\$15 copay	100% - A drug discount card is provided	100% - A drug discount card is provided
	We pay:	100% after that	0%

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. \$5,000

Premier Plus

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: \$500 \$1,000 \$1,500 \$2,000 \$2,500
\$3,500 \$5,000 \$7,500 \$10,000 \$25,000

(Your deductible for out of network is two times the in-network amount)
 \$500 deductible is not available on the 80%/20% coinsurance plan

Coinsurance after deductible		In-network		Out-of-network	
80%/20%	<input type="checkbox"/>	You pay:	20% of \$10,000	40% of \$20,000	
		We pay:	80% of \$10,000, then 100%	60% of \$20,000, then 100%	
	<input type="checkbox"/>	You pay:	20% of \$15,000	40% of \$30,000	
		We pay:	80% of \$15,000, then 100%	60% of \$30,000, then 100%	
50%/50%	<input type="checkbox"/>	You pay:	50% of \$10,000	50% of \$20,000	
		We pay:	50% of \$10,000, then 100%	50% of \$20,000, then 100%	
	<input type="checkbox"/>	You pay:	50% of \$15,000	50% of \$30,000	
		We pay:	50% of \$15,000, then 100%	50% of \$30,000, then 100%	

Your prescription drug benefits begin immediately

Simply present your Express Scripts drug 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.

The preferred list may include Generic and Brand Name drugs. 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.

There are also Specialty drugs — 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.



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
- 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 ExpressMed Comprehensive Plans

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 ExpressMed 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: 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.

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.)*

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

- 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.

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.

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.

After 2 years, benefits are payable unless specifically excluded from coverage. Conditions fully disclosed on the application and not excluded by name or specific description are covered subject to the provisions of the policy.

- 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 or treatment was recommended within a 5-year period prior to the issue date of coverage; or that which produced symptoms within a 5-year period prior to the issue date of coverage. Conditions fully disclosed on the application and not excluded by name or specific description are covered subject to the provisions of the policy.
- 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.

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. Conditions fully disclosed on the application and not excluded by name or specific description are covered subject to the provisions of the policy.
- 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 or treatment was recommended or received within a 6-month period prior to the issue date of coverage; or that produced symptoms within a 6-month period prior to the issue date of coverage. Conditions fully disclosed on the application and not excluded by name or specific description are covered subject to the provisions of the policy.
- Covered expenses include breast cancer diagnostic services and diabetes care and treatment.

Missouri

- 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.

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. Conditions fully disclosed on the application and not excluded by name or specific description are covered subject to the provisions of the policy.
- 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.

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.

Pennsylvania

- Preauthorization is not applicable.
- The pre-existing conditions definition is modified to be a condition for which medical advice was given or treatment was recommended within a 5-year period prior to the issue date of coverage; or that produced symptoms within a 5-year period prior to the date of issue. Pre-existing conditions are not covered during the first 2 years. After 2 years, benefits are payable unless specifically excluded from coverage. Conditions fully disclosed on the application and not excluded by name or specific description are covered subject to the provisions of the policy.
- 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. Conditions fully disclosed on the application and not excluded by name or specific description are covered subject to the provisions of the policy.
- Covered expenses include mammography, pap smears, prostate cancer screening, postmastectomy care, cleft lip and palate, diabetes care and treatment and for the care and treatment of psychiatric conditions (*limited benefit*).

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. Conditions fully disclosed on the application and not excluded by name or specific description are covered subject to the provisions of the policy.
- 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. Conditions fully disclosed on the application and not excluded by name or specific description are covered subject to the provisions of the policy.
- Covered expenses include clinical cancer trials, diabetes care and treatment and comprehensive adult wellness benefits (*limited benefit not subject to deductible*).

Protection from a Financially Strong Company

World Insurance Company 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.*



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 or certificate of coverage within 10 days of receiving it and your money will be promptly refunded.

Available to members of the Advisory Care Association.

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.

World Insurance Company, 11808 Grant Street, Omaha, Nebraska 68164, (402) 496-8000.

© 2008 World Insurance Company

® World Insurance and logo are registered servicemarks of World Insurance Company.

Forms: AC4800W, AC4800W-PPO
F4257

06 114 2498 0808 US