



WorldCARE™ Comprehensive at-a-Glance

	PPO Plan Designs					
	100		80		60 (Limited Benefit plan in GA.)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Available Deductibles (Maximum of 3 per family, per calendar year)	\$1,000, \$1,500, \$2,500, \$5,000, \$10,000, \$15,000, \$20,000, \$25,000	2 times PPO ded. This ded. accumulates separately from the PPO ded.	\$1,000, \$1,500, \$2,500, \$5,000, \$10,000, \$15,000, \$20,000, \$25,000	2 times PPO deductible. This ded. accumulates separately from the PPO deductible.	\$1,000, \$1,500, \$2,500, \$5,000, \$10,000, \$15,000, \$20,000, \$25,000	2 times PPO deductible. This ded. accumulates separately from the PPO deductible.
Coinsurance	100/0	80/20 of next \$10,000, subject to Usual and Customary.	80/20 of next \$5,000, \$10,000, \$15,000, \$20,000, \$50,000	60/40 of next \$10,000, \$20,000, \$30,000, \$40,000, \$100,000, subject to Usual and Customary.	60/40 of next \$5,000, \$10,000, \$15,000, \$20,000, \$50,000	50/50 of next \$10,000, \$20,000, \$30,000, \$40,000, \$100,000, subject to Usual and Customary. (In GA, coinsurance is 60/40)
Out-of-Pocket (In addition to deductible)	\$0	\$2,000; plus charges in excess of Usual and Customary.	\$1,000, \$2,000, \$3,000, \$4,000, \$10,000	\$4,000, \$8,000, \$12,000, \$16,000, \$40,000; plus charges in excess of Usual and Customary.	\$2,000, \$4,000, \$6,000, \$8,000, \$20,000	\$5,000, \$10,000, \$15,000, \$20,000, \$50,000 (In GA, \$4,000, \$8,000, \$12,000, \$16,000, \$40,000); plus charges in excess of Usual and Customary.
Lifetime Maximum	\$2,000,000 or optional \$5,000,000 or \$10,000,000.					
Physician's Office Visit	Subject to deductible and coinsurance.					
	<p>OPTIONAL:</p> <p>¹PPO Provider: \$30 copay, limited to 3 visits per calendar year. After the 3 visits max., the charges will be subject to ded. and coinsurance. Non-PPO – Subject to Out-of-Network ded. coinsurance levels.</p> <p>²PPO Provider: \$40 copay, no max. on number of visits per calendar year. Non-PPO – Subject to Out-of-Network ded. and coinsurance levels.</p>					
Prescription Drugs	Generic is covered at 100%. Brand: not covered (discount drug card is provided)					
	<p>OPTIONAL:</p> <p>¹Subject to deductible and coinsurance.</p> <p>²Generic - \$10 or 20% (whichever is greater); Brand (formulary) - \$30 or 50% (whichever is greater); Brand (non-formulary) - \$50 or 50% (whichever is greater).</p> <p>³Generic - \$20; Brand - \$200 deductible, (formulary) \$35; (non-formulary) \$50.</p>					
Maternity Benefits****	Not covered, unless Maternity Benefit option is selected; then \$10,000 deductible and 50% coinsurance of the next \$20,000. 6 month waiting period.					
Emergency Room Copayment	If you visit an Emergency Room for an <i>Illness</i> , you pay a \$250 copayment in addition to your plan ded. and coinsurance. The \$250 copayment does not apply to accidents. If you are admitted directly from the Emergency Room into the hospital as an inpatient, the copayment is waived.					
Outpatient X-Ray & Lab Benefit	Subject to deductible and coinsurance.					
	OPTIONAL: Benefit paid on a first-dollar basis, up to calendar year maximum.					
Outpatient, MRI, Cat Scan & PET Scans	Subject to deductible and coinsurance.					
	OPTIONAL: ¹ \$1,000 per test up to \$2,500 per calendar year. ² \$2,500 per calendar year. ³ 100% benefits up to your plans calendar year maximum.					
Foreign Travel Emergency	Coverage for the first 60 days with a \$100,000 limit, subject to the same ded. and coinsurance limits as the base plan.					

Not available in all states * Not available in Georgia, Ohio or Oklahoma ****Not available in all states. Please verify availability on proposal software.

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Rate Guarantee	12 month rate guarantee period. <i>OPTIONAL:</i> 2 or 3 years with \$2,500 deductible or higher.					
Wellness Benefits	\$500 per calendar year, subject to deductible and coinsurance. <i>OPTIONAL:</i> ¹ No benefits. ² \$500 per calendar year. \$40 copay. ³ 6 month waiting period. \$500 per calendar year, \$30 copay.					
<i>Additional Benefits:</i>						
Accident Expense Benefit	First Dollar Benefit of \$500, \$1,000, \$1,500, \$2,000					
Term Life	¹ Individual – \$15,000. Plus Family: Spouse - \$7,500; Child, 14 days to 6 months – \$250; Child - 6 months to 27 years – \$1,000. ² 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	Daily Benefit available in \$10 increments – from \$100 to \$200 pays a daily cash benefit (limited to 90 day Lifetime Maximum). There is a 20-day waiting period.					
Critical Illness Benefit	Cash Benefit of \$25,000 paid upon diagnosis of a critical illness.					
Accidental Death Benefit	Accident: Amounts of \$2,500, \$5,000, \$7,500, \$10,000, \$15,000, \$25,000, \$50,000, \$100,000					

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