



World Insurance Company  
P. O. Box 3160 • Omaha, NE 68103-0160 • (402) 496-8000

## Colorado Health Plan Description Form

World Insurance Company

*Name of Carrier*

WorldCARE Flex Advantage and Value Advantage

*Name of Plan*

Flex Advantage Benefit Percentage (check appropriate box):  100%     80% to \$5,000     60% to \$10,000  
Value Advantage Benefit Percentage (check appropriate box):  70% to \$10,000     50% to \$10,000

### PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Preferred Provider Plan.
2. OUT-OF-NETWORK CARE COVERED? <sup>1</sup>	Yes, but patient pays more for out-of-network care.
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Available throughout Colorado.

### PART B: SUMMARY OF BENEFITS

**Important Note:** This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance options reflect the amount you will pay.

	<b>IN-NETWORK</b> (check appropriate box if app.)	<b>OUT-OF-NETWORK</b>
4. ANNUAL DEDUCTIBLE <sup>2</sup>		
a) <u>Flex Advantage</u>		
• Individual	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000	Double the In-Network annual deductible – accumulates separately from the In-Network annual deductible.
• Family	Maximum of 3 per calendar year.	Maximum of 3 per calendar year.
b) <u>Value Advantage</u>		
• Individual	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000	Three times the Individual Annual Deductibles – In-Network and Out-of-Network deductibles accumulate separately.
• Family	Maximum of 3 per calendar year.	Maximum of 3 per calendar year.
5. OUT-OF-POCKET MAXIMUM <sup>3</sup> (check appropriate box)		
a) <u>Flex Advantage</u>		
• Individual	<input type="checkbox"/> 0% of the Covered Expenses after the Individual Deductible, plus any copays, if applicable.	30% of the first \$10,000 or covered expenses, plus charges in excess of usual and customary.
• Family	Maximum of 3 individual deductibles plus Out-of-Pocket maximums per calendar year per family; plus any copays, if applicable.	Maximum of 3 Out-of-Network deductibles plus Out-of-Pocket maximums per calendar year; plus charges in excess of usual and customary.
• Individual	<input type="checkbox"/> 20% of the first \$5,000 of Covered Expenses, if applicable, after the Individual Annual Deductible; then 100% of the remainder to the end of the calendar year.	50% of the first \$10,000 of covered expenses, plus charges in excess of usual and customary.
• Family	Maximum of 3 individual deductibles plus Out-of-Pocket maximums per calendar year per family; plus any copays, if applicable.	Maximum of 3 individual Out-of-Network deductibles plus Out-of-Pocket maximums per calendar year per family; plus charges in excess of usual and customary.

	<b>IN-NETWORK</b> <i>(check appropriate box if app.)</i>	<b>OUT-OF-NETWORK</b>
5. OUT-OF-POCKET MAXIMUM <sup>3</sup> <i>cont'd</i> <i>Flex Advantage cont'd.</i> • Individual  • Family	<input type="checkbox"/> 40% of the first \$10,000 of Covered Expenses, plus any Copays, if applicable, after the Individual Annual Deductible; then 100% of the remainder to the end of the Calendar Year. Maximum of 3 individual deductibles plus Out-of-Pocket maximums per calendar year per family; plus any copays, if applicable.	50% of the first \$20,000 of covered expenses, plus charges in excess of usual and customary.  Maximum of 3 individual Out-of-Network deductibles plus Out-of-Pocket maximums.
b) <u>Value Advantage</u> • Individual  • Family	<input type="checkbox"/> 30% of the first \$10,000 of Covered Expenses, plus any Copays, if applicable, after the Individual Annual Deductible; then 100% of the remainder to the end of the Calendar Year. Maximum of 3 individual deductibles plus Out-of-Pocket maximums per calendar year per family; plus any copays, if applicable.	50% of the first \$10,000 of covered expenses, plus charges in excess of usual and customary.  Maximum of 3 individual Out-of-Network deductibles plus Out-of-Pocket maximums per calendar year per family; plus charges in excess of usual and customary.
• Individual  • Family	<input type="checkbox"/> 50% of the first \$10,000 of Covered Expenses, plus any Copays, if applicable, after the Individual Annual Deductible; then 100% of the remainder to the end of the Calendar Year. Maximum of 3 individual deductibles plus Out-of-Pocket maximums per calendar year per family; plus any copays, if applicable.	70% of the first \$10,000 of covered expenses, plus charges in excess of usual and customary.  Maximum of 3 individual Out-of-Network deductibles plus Out-of-Pocket maximums per calendar year per family; plus charges in excess of usual and customary.
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	<i>Flex Advantage</i> – \$2 million per covered person; \$5 million with purchase of optional Maximum Benefit option. <i>Value Advantage</i> – \$1 million per covered person; \$5 million with purchase of optional Maximum Benefit option	
7a. COVERED PROVIDERS	Great-West Healthcare PPO (Sloans Lake and PHCS are available in a few areas). See provider directory for complete list.	All providers licensed or certified to provide covered benefits.
7b. With respect to network plans, are all the providers listed in 7a accessible to me through my primary care physician?	Yes.	Not applicable.
8. ROUTINE MEDICAL OFFICE VISITS <sup>4</sup>	Routine Office Visits are not covered.	
9. PREVENTIVE CARE a) Children's services b) Adults' services	a) Covered from birth to age 13. b) Limited coverage for mammography and prostate screening.	
10. MATERNITY <sup>5</sup> a) Prenatal care b) Delivery & inpatient well-baby care	Not covered, except for complications of pregnancy.	
11. PRESCRIPTION DRUGS <sup>6</sup> <u>Flex Advantage</u>	Subject to deductible and coinsurance, unless optional Prescription Drug Benefit is purchased. If purchased, a separate \$200 Rx deductible per calendar year is satisfied, per covered person. Then drug copays are as follows: Generic – \$15 or 20%*; brand name (formulary) – \$35 or 50%*; and brand name (non-formulary) – \$50 or 50%. <i>* of the drug's cost, whichever is greater.</i>	
<u>Value Advantage</u>	Not covered, unless optional Benefit Increase Option is purchased. If purchased, a separate \$500 Rx deductible per calendar year is satisfied, per covered person. Drug copays are as follows: Generic – \$10 plus 20%*; brand name (formulary) – \$25 plus 50%*; and brand name (no-formulary) – \$35 plus 50%*. Calendar year maximum of \$2,500 per covered person. <i>* of the drug's cost, whichever is greater.</i>	

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
12. INPATIENT HOSPITAL	Covered subject to deductible and benefit/coinsurance percentage, as checked under #5.	
13. OUTPATIENT/AMBULATORY SURGERY	Covered subject to deductible and benefit/coinsurance percentage, as checked under #5.	
14. LABORATORY & X-RAY	Covered subject to deductible and benefit/coinsurance percentage, as checked under #5.	
15. EMERGENCY CARE <sup>7,8</sup>	Covered subject to deductible and coinsurance. Insured person pays an additional copayment if treated at an Emergency Room for an illness and not admitted directly from the Emergency Room to the hospital as an inpatient.	
16. AMBULANCE	Covered subject to deductible and benefit/coinsurance percentage, as checked under #5.	
17. URGENT, NON-ROUTINE AFTER-	Covered subject to deductible and coinsurance. Insured person pays an additional copayment if treated at an Emergency Room for an illness and not admitted directly from the Emergency Room to the hospital as an inpatient.	
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE <sup>9</sup>	Not covered.	Not covered.
19. OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	Not covered.	Not covered.
20. ALCOHOL & SUBSTANCE ABUSE	Not covered.	Not covered.
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	Covered subject to deductible and benefit/coinsurance percentage, as checked under #5. Limited to \$50 per visit and \$2,000 per calendar year maximum.	
22. DURABLE MEDICAL EQUIPMENT	Rental covered up to purchase price of equipment, subject to deductible and coinsurance.	
23. OXYGEN	Covered subject to deductible and benefit/coinsurance percentage, as checked under #5.	
24. ORGAN TRANSPLANTS	If performed at a designated transplant facility, covered subject to deductible and coinsurance. Limited to \$500,000 per-organ maximum (\$1,000,000 per-organ maximum with purchase of optional Maximum Benefit Option). Subject to policy lifetime maximum.	Limited to \$100,000 per-organ maximum. Subject to certificate life-time maximum.
25. HOME HEALTH CARE	Covered subject to deductible and coinsurance; up to 60 visits per calendar year.	
26. HOSPICE CARE	Limited coverage; up to \$100 per day outpatient or \$200 per day inpatient, subject to deductible, coinsurance and \$30,000 per benefit period.	
27. SKILLED NURSING FACILITY CARE	Covered subject to deductible and benefit percentage, as checked under #5. Maximum of 60 days per calendar year.	
28. DENTAL CARE	Not covered, except treatment required as a result of covered injury to sound natural teeth.	
29. VISION CARE	Not covered.	Not covered.
30. CHIROPRACTIC CARE	Limited coverage subject to deductible and coinsurance at any physician; up to \$25 per day and \$500 calendar year maximum, per covered person	
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)		

**PART C: LIMITATIONS AND EXCLUSIONS**

<p>32. PERIOD DURING WHICH PREEXISTING CONDITIONS ARE NOT COVERED<sup>10</sup> <u>Flex Advantage</u></p>	<p>12 consecutive months. Conditions fully disclosed on the application and not excluded from coverage by name or specific description are covered, subject to the provisions of the policy. Any period of time that a covered person was covered under a qualifying creditable coverage will be applied to this 12-month period, if such qualifying coverage was continuous to a date not more than 90 days prior to the Policy Date.</p>
<p><u>Value Advantage</u></p>	<p>12 consecutive months. Any period of time that a covered person was covered under a qualifying creditable coverage will be applied to this 12-month period, if such qualifying coverage was continuous to a date not more than 90 days prior to the Policy Date.</p>
<p>33. EXCLUSIONARY RIDERS. Can an individual’s specific, preexisting condition be entirely excluded from the policy?</p>	<p>Yes.</p>
<p>34. HOW DOES THE POLICY DEFINE A “PREEXISTING CONDITION”?</p>	<p>A preexisting condition is a condition for which medical advice, diagnosis, care or treatment was recommended by or received from a physician within a 12-month period prior to the Policy Date of coverage for that covered person.</p>
<p>35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?</p>	<p>Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g. employer). Review them to see if a service or treatment you need is excluded from the policy.</p>

**PART D: USING THE PLAN**

<p>36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?</p>	<p>No.</p>	<p>No.</p>
<p>37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?</p>	<p>Yes.</p>	<p>Yes.</p>
<p>38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?</p>	<p>No.</p>	<p>Yes.</p>
<p>39. What is the main customer service number?</p>	<p>800-786-7557.</p>	<p>800-786-7557.</p>
<p>40. Whom do I write/call if I have a complaint or want to file a grievance?<sup>11</sup></p>	<p>Customer Service, World Insurance Company, P.O. Box 3160, Omaha, NE 68103. Phone: 800-786-7557.</p>	<p>Customer Service, World Insurance Company, P.O. Box 3160, Omaha, NE 68103. Phone: 800-786-7557.</p>
<p>41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?</p>	<p>Write to: Colorado Division of Insurance, ICARE Section, 1560 Broadway, Suite 850, Denver, CO 80202.</p>	<p>Write to: Colorado Division of Insurance, ICARE Section, 1560 Broadway, Suite 850, Denver, CO 80202.</p>
<p>42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.</p>	<p>A4024 Individual.</p>	<p>A4024 Individual.</p>
<p>43. Does the plan have a binding arbitration clause?</p>	<p>No</p>	<p>No</p>

**PART E: COST AND MEDICAL EXPENDITURES**

<p>44. What is the cost of this plan?</p>	<p>Contact your agent, his insurance company, or your employer, as appropriate, to find out the premium of this plan. In some cases, plan costs are included with this form.</p>
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**PART F: PHYSICIAN PAYMENT METHODS, AND PLAN EXPENDITURES FOR HEALTH EXPENSES,  
ADMINISTRATION AND PROFIT**

Any person interested in applying for coverage, or who is covered by, or who purchased coverage under this plan may request answers to the questions listed below. The request may be made orally or in writing to the agent marketing the plan or directly to the insurance company and shall be answered within five (5) working days of the receipt of the request.

- What are the three most frequently used methods of payment for primary care physicians?
- What are the three most frequently used methods of payment for physician specialists?
- What other financial incentives determine physician payment?
- What percentage of total Colorado premiums are spend on health care expenses as distinct from administration and profit?

Endnotes

- <sup>1</sup> Network refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it pays more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).
- <sup>2</sup> Deductible means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible may be noted in boxes 8 through 31.
- <sup>3</sup> Out-of-pocket maximum. The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy. Expenses that are applied toward the out-of-pocket maximum may be noted in boxes 8 through 31.
- <sup>4</sup> Routine Medical Office Visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically-based mental illness.
- <sup>5</sup> Well Baby Care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together; there are not separate copayments.
- <sup>6</sup> Prescription Drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.
- <sup>7</sup> Emergency care means services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.
- <sup>8</sup> Non-Emergency Care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, then urgent care copayments apply.
- <sup>9</sup> Biologically based mental illnesses means schizophrenia, schizo affective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.
- <sup>10</sup> Waiver of preexisting condition exclusions. State law requires carriers to waive some or all of the preexisting condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g. employer) for details.
- <sup>11</sup> Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.



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