without cancer coverage

WASHINGTON NATIONAL

WORKSITE critical illness®

Each year millions of Americans are diagnosed with critical illnesses. The good news is that more people are surviving such a diagnosis. Still, some of the costs associated with treatment are not paid by major medical insurance and must be paid out of your own pocket. That's where supplemental insurance can help.

Consider the facts

- 1-in-3 adults have cardiovascular disease.[1]
- Nearly 40% of cardiovascular disease costs are nonmedical and can include insurance shortfalls, transportation and lodging related to treatment, mortality costs and loss of income.[2]
- About half of all personal bankruptcies are attributed in part to medical problems.[3]

When benefits are paid*

Benefits are paid upon diagnosis in two health diagnosis categories (HDCs):

- HDC 1: Heart attack, stroke, heart transplant as a result of heart failure, and coronary artery bypass surgery
- HDC 2: Major organ transplant (other than heart), end-stage renal failure and blindness

[1] "Heart Disease and Stroke Statistics–2012 update: A Report from the American Heart Association," *Circulation*, 2012, p. 21

[2] Ibid., p. 209

[3] "Top 5 Reasons Why People Go Bankrupt," *Investopedia, March 22, 2010*

The above facts represent the U.S. population, are provided for information only and do not imply coverage under the policy or endorsement of the company or policy by the people and organizations named above.

Benefits summary

LUMP-SUM BENEFIT*

This benefit pays amounts up to $75,000 (in $5,000 increments) upon initial diagnosis of a specified critical illness while coverage is in effect.

Limit:
One lump-sum payment per HDC, per covered person

Coronary artery bypass surgery is limited to a one-time benefit of 25% of the lump-sum amount.

Amounts paid for this condition will reduce the benefit remaining in the HDC to 75%.

RECURRENCE BENEFIT*

This benefit pays 50% of the lump-sum amount when a covered person receives a subsequent diagnosis of a specified critical illness while coverage is in effect.

Limit: One recurrence benefit per HDC, per covered person

Recurrence must be diagnosed more than 24 months after any previous diagnosis of the same illness.

The covered person must be treatment-free for 24 months prior to the subsequent diagnosis. Treatment does not include maintenance medication or follow-up visits.

WELLNESS BENEFIT

This benefit pays $50 for one screening every calendar year for each covered person after the waiting period is met.

Covered wellness benefit screenings are listed on the reverse side.

COVERAGE FOR THE ENTIRE FAMILY

The spousal benefit, if purchased, is 50% of the face value of the employee's certificate.

Children are automatically covered at 10% of the coverage amount purchased by the employee.

**Diagnosis in a second HDC must occur more than 180 days after the first diagnosis in another category.*

Limitations and exclusions

Benefits will not be paid for loss contributed to, caused by or resulting from any other disease, sickness or incapacity, even if the disease or condition was caused, complicated or aggravated by the specified critical illness;[1] diagnosis of a specified critical illness during the waiting period (the waiting period is the first 30 days following the effective date of coverage); participating or attempting to participate in an illegal act[2] or working at an illegal job; being legally intoxicated or so intoxicated that mental or physical abilities are seriously impaired, being under the influence of any illegal drugs or being under the influence of any narcotic, unless such narcotic was taken under the direction of and as directed by a physician;[3] injuring or attempting to injure yourself intentionally, regardless of mental capacity; committing or attempting to commit suicide,[4] regardless of mental capacity;[5] participating in any sporting event for pay or prize money; being exposed to war or any act of war, declared or not, or participating in or contracting with the armed forces (including Coast Guard) of any country or international authority;[6] and alcoholism, drug abuse or chemical dependency.

No benefits are payable for a pre-existing condition during the first 12 months after the effective date of coverage. A pre-existing condition is the existence of symptoms that would cause an ordinarily prudent person[7] to seek diagnosis, care or treatment within a 12-month period preceding the effective date of coverage of the covered person,[8] or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a 12-month period preceding the effective date of coverage. A pre-existing condition can exist even though a diagnosis has not yet been made.

Heart benefits are not payable for any other disease or injury involving the cardiovascular system or any heart attacks occurring during or as the result of any medical procedures. Cardiac arrest not caused by myocardial infarction is not a heart attack. The benefit for coronary artery bypass surgery is limited to 25% of the lump-sum benefit amount.

Loss-of-sight benefits are not payable for blindness if in general medical opinion any procedure, device or implant could result in a partial or total restoration of sight, for persons under the attained age of 3 on the date of diagnosis, and for reduction of sight that occurs prior to the effective date of coverage under this policy.

Renal-failure benefits are not payable for renal failure caused by a traumatic event, including surgical trauma.

The recurrence benefit is payable only when these conditions are met: The recurrent specified critical illness is diagnosed more than 24 months after any previous diagnosis of the same specified critical illness; no treatment (which does not include maintenance medications and follow-up physician visits) is received during the 24 months between the diagnosis for the same specified critical illness; the additional diagnosis is made while the coverage is in force; and the loss is not excluded by name or specific description.

Policy form (may vary by state): CIC1034

Washington National Insurance Company
Home Office
11825 N. Pennsylvania Street
Carmel, IN 46032

WashingtonNational.com

(01/13) 146223
W2-FS-WOC

[1] In Arkansas, "any other disease, sickness or incapacity, even if the disease or condition was caused, complicated or aggravated by a specified critical illness" is not applicable.

[2] In Pennsylvania, "participating or attempting to participate in a felony act."

[3] In Pennsylvania, narcotics must be administered by a physician.

[4] In Pennsylvania, "attempting to commit" suicide is not applicable.

[5] In Pennsylvania, "regardless of mental capacity" is not applicable.

[6] In Pennsylvania, "war or any act of war, declared or not, or participating in or contracting with the armed forces (including Coast Guard) of any nation while on active duty. We will return, at your request, the prorated premium paid for any period you are not insured by this policy while you are in such service."

[7] In the District of Columbia, the definition of pre-existing condition does not contain "ordinarily prudent".

[8] In Pennsylvania and South Carolina, the definition of pre-existing condition does not contain "the existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a 12-month period preceding the effective date of coverage of the covered person."

Covered wellness benefit screenings include:
- *Stress test on a bicycle or treadmill*
- *Fasting blood glucose test*
- *Blood test for triglycerides*
- *Serum cholesterol test to determine level of HDL and LDL*
- *Electrocardiogram*
- *Carotid Doppler*
- *Echocardiogram*
- *Lipid panel*

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