Washington National®

WASHINGTON NATIONAL

SOLUTIONS® Cancer

SUPPLEMENTAL CANCER INSURANCE

Benefits. Options. Advocacy.

PLAN **D**

CN-BR-TN-D-IND

YOUR GUARANTEES FROM WASHINGTON NATIONAL

- **Benefits are paid directly to you** regardless of any other insurance you have.[6]
- **Only you can cancel** your coverage.[7]
- **Rates won't increase** just because you use your policy's benefits.[8]

Each year, millions of Americans are diagnosed with cancer.

What are the chances that someone in your family will be one of them?

According to the American Cancer Society:

- Nearly **1-in-2 men**—and more than **1-in-3 women**—are expected to develop cancer at some point in their lifetime.[1]
- Cancer is the **second-leading cause of death** in children 14 and younger.[2]
- Approximately **15.5 million Americans** alive today have a history of cancer.[3]

The good news: *Thanks to early detection and advanced treatment, survival rates are increasing.*

But treatments cost money. And they may not be covered by your major medical policy.

The annual cost of cancer-related health care in the U.S. is roughly **$87.8 billion**.[4] Major medical insurance covers some of a cancer patient's treatment costs, but not all.

On average, cancer patients spend **$703** out of pocket **each month** on treatments alone.[5]

And this amount doesn't account for nonmedical costs, which could include:

- Insurance shortfalls, such as deductibles, copayments and benefit limitations.
- Special expenses like transportation, lodging and family care.
- Loss of income when the patient is unable to work.
- Living expenses, including mortgage or rent payments, car loans, utilities and groceries.

How would you pay for the out-of-pocket expenses of cancer?

- Spend your life savings.
- Sell off assets.
- ***Purchase supplemental insurance.***

Your cancer concerns don't stop at the doctor's door. Neither should your insurance. Washington National offers a solution.

[1]American Cancer Society, *Cancer Facts & Figures 2017*, 2017, p. 2.
[2]Ibid., p. 12.
[3]Ibid., p. 1.
[4]Ibid., p. 9.
[5]Forbes, *Even Insured Patients are Overwhelmed by the Cost of Cancer Care,* https://www.forbes.com/sites/arleneweintraub/2017/08/10/even-insured-patients-are-overwhelmed-by-the-cost-of-cancer-care, August 10, 2017.
[6]Unless otherwise requested by you or required.
[7]As long as your premiums are paid when due. Only you can cancel your coverage.
[8]Your rates cannot be increased unless all rates of the same kind are raised in your state.

The above facts represent the U.S. population, are provided for information only and do not imply coverage under the policy. The company and/or policy are not endorsed by the American Cancer Society.

PLAN D BENEFITS

DIAGNOSIS BENEFIT

BENEFIT	AMOUNT	INFORMATION
First-occurrence express payment	**$1,000**	This benefit is payable by overnight delivery when any covered family member is diagnosed with any type of internal cancer, except skin cancer, and submits acceptable proof of diagnosis. Children will receive a 50% increased benefit. This way, you will have immediate financial assistance to help with the extra expenses associated with cancer. In most areas, delivery is guaranteed within two days! This benefit is payable only once for each covered person.
Additional units first-occurrence express payment	**$1,000 to $19,000**	Up to 19 additional units ($1,000 per unit) are available for a maximum express payment benefit of $20,000. Children will receive a maximum benefit of $30,000.

Health Advocate℠: Our signature feature

Making phone calls, handling arrangements, filing paperwork….When you're dealing with health issues, you don't have to handle it all by yourself. With your Washington National Solutions Cancer policy, you have immediate access to helpful support from Health Advocate.

Your personal Health Advocate is an R.N. backed by medical directors and administrative experts. Health Advocate can help you:

- Navigate the health care system.
- Find physicians and facilities.
- Access valuable resources.
- Resolve claims and billing issues.

For immediate support, call Health Advocate at (866) 695-8622.

IN-HOSPITAL BENEFITS

BENEFIT	AMOUNT	INFORMATION
Inpatient hospital confinement includes U.S. government hospitals	**$250** per day, 1–30 days **$500** per day, 31+ days	Benefits are paid for each day you are confined as an inpatient in a hospital due to cancer. For confinements in a U.S. government hospital, this benefit amount is paid in lieu of all other benefits—except the first-occurrence express payment, transportation (covered person), transportation (family member) and lodging benefits.
Inpatient drugs and diagnostic testing	Actual charges up to **$50** per day	Benefits are paid for drugs and medicine, including diagnostic and laboratory tests and X-rays necessary for the diagnosis and treatment of cancer approved by the FDA, NCI or recognized in any of the standard reference compendia or in substantially accepted peer-reviewed medical literature. Benefits are payable for up to the same number of days you receive benefits for hospital confinement.
Attending physician	Actual charges up to **$40** per day	Benefits are paid per covered confinement for cancer-treatment services by a physician other than your surgeon. Benefits are payable for up to the same number of days you receive benefits for hospital confinement.
Private nurse	Actual charges up to **$125** per day	Benefits are paid when your doctor prescribes the full-time services of an L.P.N., L.V.N. or R.N. during a covered hospital confinement. Services must be provided by someone other than a spouse or family member, and be other than those regularly furnished by the hospital. Benefits are payable for up to the same number of days you receive benefits for hospital confinement.

IN-HOSPITAL BENEFITS

BENEFIT	AMOUNT	INFORMATION
Transportation (covered person)	Actual charges up to **$2,500** for coach-class plane, train or bus transportation or **40 cents** per mile for transportation by car	Benefits are paid for a one-way trip by coach-class plane, train, bus or car if you must travel more than 100 miles one way within the continental U.S. (including Alaska, Hawaii and Puerto Rico). Transportation must be from your home to receive covered cancer treatments that are prescribed by your physician and are not available locally. There is no limit to the number of trips. National Cancer Institute (NCI) This transportation benefit also applies for consultation at a comprehensive or clinical cancer center recognized by the National Cancer Institute.
Transportation (family member)	Actual charges up to **$2,500** for coach-class plane, train or bus transportation or **40 cents** per mile for transportation by car	Benefits are paid for one immediate family member for a one-way trip by coach-class plane, train, bus or car if the same trip is not paid under the transportation (covered person) benefit. Transportation is limited to two one-way trips per period of confinement from the family member's home to the hospital in which the covered person is confined. The hospital must be more than 100 miles one way within the continental U.S. from each person's home (including Alaska, Hawaii and Puerto Rico). This benefit is provided to the covered person for a family member to travel to and/or from the city where a covered person is confined to receive covered cancer treatments that are prescribed by a physician and are not available locally.
Family member lodging	Actual charges up to **$70** per day	Benefits are paid for one immediate family member's lodging, in one room per day, for up to 60 days per period of the covered person's confinement. Lodging must be more than 100 miles one way within the continental U.S. from each person's home (including Alaska, Hawaii and Puerto Rico). The benefit is provided to the covered person for a family member to lodge in the city where the covered person is confined to receive covered cancer treatments that are prescribed by a physician and are not available locally.
Ambulance	Actual charges up to **$250** per one-way trip	This benefit is paid for each one-way trip to or from a hospital where you are confined as an inpatient, for up to two one-way trips per confinement. Benefits include air ambulance when necessary to protect your health and safety and no other travel methods are available.

IN- OR OUT-OF-HOSPITAL BENEFITS

BENEFIT	AMOUNT	INFORMATION
Second and third surgical opinion	Actual charges up to **$250** per opinion	Benefits are paid for second and third medical evaluations of your need for surgery (other than for skin cancer) at your option.
Surgery	**$135 to $9,000**	Benefits are paid for each operation that diagnoses or treats cancer, based on the schedule listed in your policy. If more than one procedure is performed through the same incision at the same time, we will pay for the one with the largest benefit amount. Biopsy surgery Benefits also are paid for surgical biopsies leading to positive cancer diagnosis, based on the surgical schedule listed in your policy.
Reconstructive breast surgery	**Actual charges**	Benefits are provided by the base plan only. We will pay for all stages of breast reconstruction of mastectomy performed within five years. Benefits will pay for all stages of reconstructive breast surgery on the diseased and nondiseased breast. Reconstructive surgery on the non-diseased breast is to make it equal in size with the diseased breast after reconstruction surgery on the diseased breast has been performed. If reconstructive surgery is performed the same day as the procedure to implant a prosthetic device, we will pay only for the procedure having the higher benefit.
Mammography	**$25** per calendar year	Benefits are provided by the base plan only and are paid for a covered person's mammography examination when performed as followed: One baseline mammogram for a covered person between ages 35 and 39, inclusive. One mammogram every two years for a covered person between ages 40 and 49, inclusive, or more frequently based on the physician's recommendation. An annual mammogram for a covered person 50 years of age and older.

IN- OR OUT-OF-HOSPITAL BENEFITS

BENEFIT	AMOUNT	INFORMATION
Blood and plasma	**$80** per unit	Benefits are paid for each unit of blood you receive for cancer treatment. This includes donated blood, plasma and platelets.
Anesthesia	**$34 to $2,250**	Benefits are paid for each operation, based on the schedule listed in your policy. If more than one surgical procedure is performed at the same time, we will pay for the anesthesia with the largest benefit amount. Benefits also are paid for surgical biopsy anesthesia leading to a positive cancer diagnosis, based on the schedule listed in your policy.
Prosthetics (surgical)	Actual charges up to **$3,000** per device	Benefits are paid for surgically implanted prosthetic devices needed due to, and received within three years of, a covered surgery as prescribed by a physician due to cancer.
Prosthetics (nonsurgical)	Actual charges up to **$250**, lifetime maximum per covered person	Benefits are paid for nonsurgically implanted devices received within three years of a covered surgery as prescribed by a physician due to cancer. Devices include voice boxes, removable breast prostheses and ostomy pouches.
Radiation therapy	Actual charges up to **$300** per day	Benefits include, but are not limited to, the insertion of an interstitial or intracavity application of radium or radioisotopes. The surgery benefit provides additional amounts payable for insertion and removal. There is no monthly or lifetime maximum limit to this benefit.
Chemotherapy (injected by medical personnel)	Actual charges up to **$300** per day	Benefits include cytotoxic chemical substances and their administration. Injections must be made by medical personnel in a physician's office, clinic or hospital. Benefits are payable on the date of the treatment. Experimental treatments are covered as long as treatment is investigationally approved by the U.S. Food and Drug Administration. There is no monthly or lifetime maximum limit to this benefit.
Chemotherapy (self-administered)	Actual charges up to **$300** per drug	Benefits include self-injected medications, medications dispensed by a pump or implant, or oral chemotherapy, regardless of where it is administered. This benefit is limited to a monthly maximum of $2,400. Experimental treatments are covered as long as treatment is investigationally approved by the U.S. Food and Drug Administration. There is no lifetime maximum limit to this benefit.
Comfort drugs (outpatient)	Actual charges up to **$150** per month	Benefits are paid for outpatient medication prescribed to treat nausea associated with cancer treatments.
Medical imaging	**$200** per calendar year	This benefit is paid when a covered person receives an initial diagnosis or follow-up evaluation of internal cancer using a medical imaging exam. This includes but is not limited to CT scan, MRI, bone scan and PET scan. This benefit is limited to one payment for each calendar year for each covered person.
Stem cell transplant	Actual charges up to **$2,500**, lifetime maximum per covered person	Benefits are paid for a stem cell transplant for the treatment of cancer. This benefit does not pay for a bone marrow transplant. We will pay this benefit once per lifetime for each covered person.
Bone marrow transplant	**$10,000**, lifetime maximum per covered person	Benefits are paid for a bone marrow transplant for the treatment of cancer. This benefit does not pay for a stem cell transplant. We will pay this benefit once per lifetime for each covered person.
Wigs and hairpieces	Actual charges up to **$250,** lifetime maximum per covered person	This benefit is paid for a wig or hairpiece needed due to cancer treatments for which you receive benefits under this policy.

IN- OR OUT-OF-HOSPITAL BENEFITS

BENEFIT	AMOUNT	INFORMATION
Home health care	**$40** per visit	Benefits are paid when you have been confined to a hospital for the treatment of cancer and receive home health care by a licensed, certified provider within seven days of release from a hospital as prescribed by your physician. Benefits are paid for up to 10 visits per confinement and 30 visits per year. This benefit is not payable at the same time as the hospice benefit.
Skilled nursing facility	Actual charges up to **$150** per day	Benefits are paid when your doctor prescribes confinement to a skilled nursing facility, due to cancer, within 14 days after a covered hospital confinement. Benefits are payable for up to the same number of days you received the hospital confinement benefit during the most recent hospital confinement.
Hospice	**$120** per day for the first 60 days; **$60** per day for an unlimited number of days thereafter	Benefits are paid for care provided at home or in a hospice facility by a licensed hospice to a terminally ill patient who is no longer receiving definitive cancer treatment and is expected to live six months or less. This benefit is not payable at the same time as the home health care benefit.
Wellness benefit	Actual charges up to **$50** per calendar year	After the 30-day eligibility period has been met, benefits are paid for the following screenings for each covered person: breast ultrasound, Pap smear (lab and procedure), biopsy, chest X-ray, CEA/CA 125 (blood test for colon and ovarian cancer), PSA (blood test for prostate cancer), colonoscopy, etc. This benefit is limited to one test per calendar year. The policy contains a complete list of covered tests. This is a preventive benefit. Diagnosis of cancer is not required for this benefit to be payable. There is no lifetime maximum limit for this benefit.

ALTERNATIVE CARE RIDER

Washington National provides another solution to help in the fight against cancer. According to the National Center for Complementary and Integrative Health, alternative methods can help patients manage pain, nausea and other side effects of treatment.[1]

To ensure you can access a variety of treatments, we offer you the Alternative Care rider.

BENEFIT	AMOUNT	INFORMATION
Integrative assessment and education benefit	Actual charges up to **$250**, one-time benefit	Benefits are paid for assessment and education services performed by an accredited practitioner of alternative care services.
Ameliorative benefit	Actual charges up to **$50** per visit	Benefits are paid for visits to an accredited practitioner for acupuncture, massage therapy, biofeedback and hypnosis. This benefit is limited to 20 visits per calendar year.
Curative benefit	Actual charges up to **$100** per visit	This benefit is paid for visits to the following types of accredited practitioners: naturopathic, homeopathic, ayurvedic and herbalist. The benefit is limited to 20 visits per calendar year. The benefit amount applies to charges for the visit with the practitioner, as well as charges for any nutritional medications and supplements.
Lifestyle benefit	Actual charges up to **$50** per visit	Benefits are paid for an accredited practitioner for the following types of alternative care: smoking cessation, yoga, meditation, relaxation techniques, tai chi and nutritional counseling. The benefit is limited to 20 visits per calendar year.

Benefits are payable only upon the diagnosis of internal cancer. The diagnosis must be reconfirmed on a regular basis, either by proof of ongoing treatment or a doctor's certification. This optional rider has an additional cost (form CHIC-8022).

[1]National Center for Complementary and Integrative Health, *Complementary, Alternative, or Integrative Health: What's In a Name?*, https://nccih.nih.gov/health/integrative-health, June 2016.

CANCER PREVENTIVE CARE RIDER

These benefits help keep pace with medical advances, enabling earlier detection of cancer and better post-treatment care for cancer survivors. Developments are helping more people overcome cancer than ever before. In the last 30 years, cancer survival rates in the U.S. have increased about 20%.[1] The benefits are payable whether or not cancer is diagnosed. All four of the rider's benefits are payable in addition to any other insurance.

BENEFIT	AMOUNT	INFORMATION
Cancer screening wellness	**$50** per calendar year	This benefit pays for one cancer test[2] in a calendar year, even when it's covered by other insurance.
Additional screening and treatment	**$50** per calendar year	This benefit is payable for a second cancer screening or preventive treatment based on an abnormal result of your initial screening that we paid for.
Skin cancer diagnosis	**$300** upon initial diagnosis	This one-time benefit is payable when skin cancer is diagnosed.
Annual care[3]	**$750** per year for up to five consecutive years per covered person	This benefit helps cover the cost of medical follow-up for cancer survivors. It activates on the anniversary of the base policy's first-occurrence benefit payment. To receive the benefit, the covered person must be under the active care of a physician.

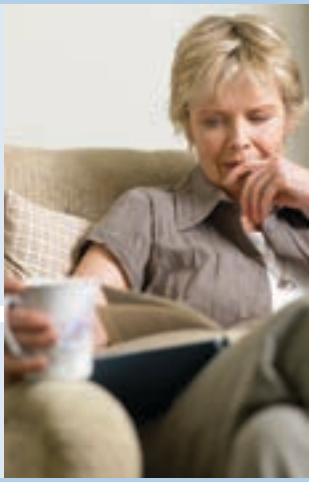
This optional rider has an additional cost (form CHIC-8063-TN).

Your benefits can be used even when you don't have cancer.

Here's an example:

Sharon, 40, went in for her first annual mammogram this year. When the test turned up a suspicious area, her doctor ordered a needle biopsy. A few days later, Sharon received the good news: She didn't have cancer!

Even so, Sharon's Cancer Preventive Care rider paid her $50 for the first screening and $50 for the needle biopsy.



This rider can keep paying even after treatment.

If the news is different for Sharon, her outlook is better due to medical advances. Plus, she'll be covered during and after treatment with the Cancer Preventive Care rider.[4]

CANCER DEATH BENEFIT RIDER

While many cancers today are highly treatable, others are much more difficult to manage. The survival rate is relatively low when cancer is detected in the pancreas, liver, lungs/bronchus, esophagus or stomach.[5] When the battle against cancer is lost, the Cancer Death Benefit rider offers financial support in a family's greatest time of need.

BENEFIT	BENEFIT AMOUNT	BENEFIT INFORMATION
Cancer death	**$5,000**	The benefit is available when a covered person dies due to cancer. It is payable in addition to any other insurance, even when cancer is not diagnosed until after death.[6]

This optional rider has an additional cost (form CHIC-8062).

[1]American Cancer Society, *Cancer Facts & Figures 2017*, 2017, p. 3.
[2]See your policy for full list of covered screenings.
[3]This benefit is not available for skin cancer.
[4]Annual payments are $750 for a five-year maximum benefit amount of $3,750.
[5]American Cancer Society, *Cancer Facts & Figures 2017*, 2017, p. 21.
[6]For this benefit to be paid, the covered person's death certificate must list cancer as the primary or a contributing cause of death.

Limitations and exclusions

You will be eligible for benefits if: you have not been diagnosed with or treated for any cancer before the effective date of coverage; you are not diagnosed with or treated for any cancer during the first 30 days after your effective date; cancer is first diagnosed while you are covered under this policy; you incur a loss due to cancer while covered under this policy; your loss is not excluded by name or specific description.

The benefits described in the policy or rider do not cover all nonmedical expenses. However, the benefit payment you receive can be used to pay any of your medical or nonmedical costs not paid by any other insurance.

Benefits are not payable for: any other disease, sickness or incapacity, even if the disease was caused, complicated or aggravated by cancer or cancer treatment; losses occurring before or during the 30-day eligibility period; losses occurring while the coverage is not in force; a pre-existing condition: If any cancer is first diagnosed before your effective date of coverage under this policy or during the first 30 days after your effective date of coverage, we will only provide benefits for loss due to cancer commencing 24 months after your effective date of coverage.

If the Alternative Care rider is chosen, we will not pay charges for nutritional medications and supplements prescribed or recommended by any accredited practitioner during the course of treatment, regardless of where they are dispensed, except under the curative benefit.

If an employer pays, or is treated as paying, all or part of the premium, the benefit may be considered taxable income unless excluded under one or more provisions of the Internal Revenue Code. You should consult your tax adviser for specific information.

This brochure is intended to be a brief, general description of coverage. For more complete details of coverage, including benefits, limitations and exclusions specific to your state, please review the policy with your agent.

DEFINITIONS

Hospital: A hospital is not a bed, unit or facility that functions as a/an: skilled nursing facility, nursing home, extended care facility, convalescent home, rest home, home for the aged, sanatorium, rehabilitation center, place primarily providing care for alcoholics or drug addicts or facility for the care and treatment of mental disease or mental disorders.

Waiver of premium: After the policyholder is disabled from cancer for more than 90 consecutive days, premium payments are not required to keep the insurance in force as long as disability due to cancer continues. Disability must occur prior to the policyholder's 65th birthday. Must be diagnosed with cancer 30 days or more after the effective date of coverage under this policy.

For the purpose of this policy, standard reference compendia means:

(A) The United States Pharmacopoeia Drug Information;
(B) The American Medical Association Drug Evaluations;
(C) The American Hospital Formulary Service Drug Information;
(D) The Comprehensive Cancer Network Drugs and Biologics Compendium;
(E) The Thompson Micromedex's Drug Dex; or
(F) The Elsevier Gold Standard Clinical Pharmacology.

Policy form series: CHIC-5022I-TN

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