

WMI MUTUAL INSURANCE COMPANY
SCHEDULE OF BENEFITS SUMMARY
Arizona Silver 2 Plan

Eligible services and treatments are covered at the benefit levels shown below, and are subject to all other terms, limitations, and exclusions as set forth in the Policy.

	PPO PROVIDERS	NON-PPO PROVIDERS
<p>This plan covers Essential Benefits. "Essential Benefits" means: 1) Ambulatory patient services; 2) Emergency services; 3) Hospitalization; 4) Maternity and newborn care; 5) Mental health and substance abuse, including behavioral health treatment; 6) Prescription drugs; 7) Rehabilitative and habilitative services and devices; 8) Laboratory services; 9) Preventive and wellness services and chronic disease management; and 10) Pediatric services, including oral and vision care. There are no annual or lifetime dollar limits applicable to essential benefits. Any benefit-specific dollar limits referenced in the Schedule of Benefits pertain only to those health care services and supplies that are not essential benefits.</p>		
<p>DEDUCTIBLE PER CALENDAR YEAR: Deductible does not apply to PPO preventive and wellness services.</p>		
Per Individual	\$2,000 for medical and Prescription Drug services	
Per Family	\$4,000 for medical and Prescription Drug services	
<p>MAXIMUM OUT-OF-POCKET AMOUNT PER CALENDAR YEAR: Amounts paid for non-covered care or treatment do not apply towards the Out-of-Pocket amounts.</p>		
Per Individual	\$4,000 for medical and Prescription Drug services	
Per Family	\$8,000 for medical and Prescription Drug services	
<p>The Plan will pay the designated coinsurance percentage of Covered Services until Out-of-Pocket amounts are reached, at which time the Plan will pay 100% of Covered Services during the Calendar Year.</p>		
COVERED SERVICES	PPO PROVIDERS (coinsurance amount paid by the Plan)	NON-PPO PROVIDERS (coinsurance amount paid by the Plan)
<p>Note: Any visit maximums listed below are the total for PPO and Non-PPO expenses combined. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between PPO and Non-PPO providers</p>		
Hospital Services		
<ul style="list-style-type: none"> • Room and Board 	70% after Deductible, of the facility's semi-private room rate	55% after Deductible, of the facility's semi-private room rate
<ul style="list-style-type: none"> • Intensive Care 	70% after Deductible, of the hospital's ICU charge	55% after Deductible, of the hospital's ICU charge
<ul style="list-style-type: none"> • Skilled Nursing Facility 	70% after Deductible, of the facility's semi-private room rate, limited to 90 days per Calendar Year	55% after Deductible, of the facility's semi-private room rate, limited to 90 days per Calendar Year
Outpatient hospital and	70% after Deductible	55% after Deductible

ambulatory patient services		
Emergency Department Services	70% after Deductible	70% after Deductible, if services are for an Emergency* as defined below, otherwise, 55% after Deductible
<p>*Emergency means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, and that failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.</p>		
Physician Services		
• Inpatient Visits	70% after Deductible	55% after Deductible
• Office Visits/Specialist Visits	70% after Deductible	55% after Deductible
• Surgery	70% after Deductible	55% after Deductible
Home Health Care	70% after Deductible, limited to 30 visits per Calendar Year	55% after Deductible, limited to 30 visits per Calendar Year
Laboratory tests, diagnostic x-rays, ultrasounds	70% after Deductible	55% after Deductible
Imaging (MRI, CAT/PET scans)	70% after Deductible	55% after Deductible
Hospice Care	70% after Deductible	55% after Deductible
Ambulance Service	70% after Deductible	55% after Deductible
Jaw Joint/TMJ	70% after Deductible	55% after Deductible
Physical Therapy, Occupational Therapy and Speech Therapy for Rehabilitative and Habilitative purposes	70% after Deductible, limited to 60 visits per Calendar Year on a combined basis	55% after Deductible, limited to 60 visits per Calendar Year on a combined basis
Habilitative Services	50% after Deductible	40% after Deductible
Durable Medical Equipment (Limited to no more than purchase price)	70% after Deductible	55% after Deductible
Prosthetics	70% after Deductible	55% after Deductible
Orthotics	70% after Deductible	55% after Deductible
Spinal Manipulation and Modalities	70% after Deductible, limited to 20 visits per Calendar Year	55% after Deductible, limited to 20 visits per Calendar Year
Mental Illness Treatment		
• Inpatient	70% after Deductible	55% after Deductible
• Outpatient	70% after Deductible	55% after Deductible
Alcohol/Substance Abuse Treatment		
• Inpatient	70% after Deductible	55% after Deductible
• Outpatient	70% after Deductible	55% after Deductible
Organ Transplants and Joint Implants (refer to Plan for specific types)	70% after Deductible	55% after Deductible
Maternity Services	70% after Deductible	55% after Deductible
Circumcisions (must be	70% after Deductible, limited to	55% after Deductible, limited to

performed within 30 days of birth)	\$150	\$150
Sleep studies	70% after Deductible, limited to \$2,500 per Calendar Year	55% after Deductible, limited to \$2,500 per Calendar Year
Sleep apnea treatment	70% after Deductible; treatments that are not Essential Benefits are limited to \$5,000 per Calendar Year	55% after Deductible; treatments that are not Essential Benefits are limited to \$5,000 per Calendar Year
Preventive Care		
<ul style="list-style-type: none"> • U.S. Preventive Services Task Force screening and tests with a rating of A or B 	100% (not subject to Deductible)	55% after Deductible
<ul style="list-style-type: none"> • Routine immunizations for children, adolescents and adults¹ 	100% (not subject to Deductible)	55% after Deductible
¹ Subject to the guidelines as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control		
<ul style="list-style-type: none"> • U.S. Health Resources and Services Administration screening and tests for infants, children, adolescents and women 	100% (not subject to Deductible)	55% after Deductible
<ul style="list-style-type: none"> • Routine physical examinations and check-ups, including well baby/child visits² 	100% (not subject to Deductible)	55% after Deductible
² Includes office visits, influenza immunizations, gynecological exams, and lab tests required for the examination		
<ul style="list-style-type: none"> • Prostate cancer screening 	100% (not subject to Deductible)	55% after Deductible
<ul style="list-style-type: none"> • Colonoscopy screening³ 	100% (not subject to Deductible)	55% after Deductible
³ Beginning at age 50 and subject to the U.S. Preventive Services Task Force and Centers for Disease Control and Prevention guidelines.		
<ul style="list-style-type: none"> • Mammography⁴ 	100% (not subject to Deductible)	55% after Deductible
⁴ Frequency limits for mammogram: A baseline mammogram for any woman who is thirty-five (35) through thirty-nine (39) years of age. A mammogram every two (2) years for any woman who is forty (40) through forty-nine (49) years of age, or more frequently if recommended by the Insured's Physician or Practitioner. A mammogram every year for any woman who is fifty (50) years of age or older.		
Other General Covered Services and Supplies (as set forth in the Plan)	70% after Deductible	55% after Deductible
Pediatric Vision (coverage is only available for Children through the age of 18)		
<ul style="list-style-type: none"> • Vision screening 	70% after Deductible; limited to one test per Calendar Year	55% after Deductible; limited to one test per Calendar Year

• Prescription lenses	70% after Deductible; limited to one pair per Calendar Year	55% after Deductible; limited to one pair per Calendar Year
• Frames	70% after Deductible; limited to one pair per Calendar Year	55% after Deductible; limited to one pair per Calendar Year
• Contacts	70% after Deductible; limited to once per Calendar Year in lieu of lenses and frames	55% after Deductible; limited to once per Calendar Year in lieu of lenses and frames
Coinsurance amount paid by the Plan		
Pediatric Dental (coverage is only available for Children through the age of 18)		
• Diagnostic and Preventive Services	70% after Deductible	
• Restorative, Endodontic and Periodontic Services	70% after Deductible	
• Prosthodontic Services	70% after Deductible	
• Orthodontic Services (orthodontic treatment for cosmetic purposes is not covered; must be enrolled for 24 months before benefits are available)	70% after Deductible	
• General Services	70% after Deductible	
Coinsurance amount paid by the Plan		
Prescription Drugs – coverage is subject to all Policy guidelines. A Generic drug must be used whenever a Generic equivalent is available. If a Brand drug is purchased instead of a Generic equivalent, the Insured is responsible for the price difference.		
• Generic Drugs	75% after Deductible	
• Brand Drugs	50% after Deductible	
• Specialty Drugs	50% after Deductible	